

# Bupa Care Services NZ Limited - Te Whanau Rest Home & Hospital

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## 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:

<b>Legal entity:</b>	Bupa Care Services NZ Limited
<b>Premises audited:</b>	Te Whanau Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 12 July 2017    End date: 13 July 2017
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	50

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Bupa Te Whanau Rest Home and Hospital is certified to provide hospital (medical and geriatric) and rest home level care for up to 65 residents. There were 50 residents on the day of audit.

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

At the time of the audit the care home manager was on leave. The service was being managed by a Bupa relieving care home manager who is a registered nurse with 16 years' experience of managing Bupa aged care facilities. She is supported by a clinical manager who has recently resigned and was orientating the newly appointed clinical manager to the service.

The following improvements have been identified around, medication management, care planning, restraint, quality and risk management and staffing.

## 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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Bupa Te Whanau Rest Home and Hospital endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural needs are identified. There was evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented. Opportunities for improvements are identified.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. The integrated residents' files are appropriate to the service type.

## 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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There is an admission package available prior to or on entry to the service. Residents' records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. Residents' files include at a minimum, three-monthly reviews by the general practitioner (GP). There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner.

An integrated activities programme is implemented that meets the needs of aged care residents. The programme includes community visitors and outings, entertainment and activities.

All food and baking is done on site. Residents' nutritional needs are identified and documented. Choices are available and are provided. The organisational dietitian reviews the Bupa menu plans.

## 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.

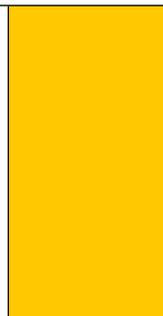
The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services.

The majority of rooms are single. There are three shared rooms. There are adequate numbers of toilets and showers. 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 and easily accessible.

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.

## Restraint minimisation and safe practice

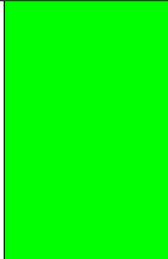
Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Restraint minimisation and safe practice policies are in place. Staff are provided with training in restraint minimisation and challenging behaviour management. At the beginning of the audit two residents had been identified as using restraint and three with enablers.

## 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 (the clinical manager) 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)
<b>Standards</b>	0	44	0	5	1	0	0
<b>Criteria</b>	0	95	0	5	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (five caregivers, three who work in both areas, one who works in the rest home and one who works in the hospital, two registered nurses and one activity coordinator, the clinical manager, the orientating clinical manager and the Bupa relieving care home manager), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident in all eight resident files reviewed. General consent forms were evident in the eight files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Enduring power of attorney evidence is sought prior to admission, and activation documentation is obtained and both are filed with the admission agreements. Where legal processes are ongoing to gain EPOA, this is recorded, as are letters of request to families for the supporting documentation. Residents interviewed confirmed that consent was obtained before undertaking any care or</p>

		treatment.
<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>Information about the national Health and Disability Advocacy service is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility in three languages. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</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>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they can participate in as much as they can safely and desire to do.</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 procedure is provided to residents and relatives at entry to the service. A record of all complaints received is maintained by the care home manager using a complaints' register. The complaints register review included verbal and written complaints (three for 2016 and 2017 year-to-date) with evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, meeting timelines, corrective actions when required, and resolutions.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestion box are placed at reception.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All seven residents (five rest home and two hospital level including one younger person with a disability) interviewed, reported that the residents' rights are being upheld by the service. Interviews with residents and four family members (three hospital and one rest home) also confirmed their understanding of the Code</p>

		and its application to aged residential care and residential disability care.
<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>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff have received training.</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 is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. One Māori resident interviewed (hospital) confirmed that Māori cultural values and beliefs are being met.</p> <p>Māori consultation is available through the documented iwi links. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</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 identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p> <p>All care plans reviewed included the resident's spiritual and cultural needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p> <p>Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-</p>

		esteem. Caregivers interviewed could describe how they build a supportive relationship with each resident.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day (link 1.2.8.1). A house GP visits the facility two days a week and an after-hour's service is provided. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The GP interviewed is satisfied with the level of care that is being provided.</p> <p>Physiotherapy services are provided on-site fortnightly. A dietitian is also available for consultations. There is a regular in-service education and training programme for staff. A podiatrist is on-site every six weeks. The service has links with the local community and encourages residents to remain independent.</p> <p>Bupa Te Whanau is benchmarked against other Bupa services. If the results are above the benchmark, a corrective action plan is developed by the service (link 1.2.3.6).</p> <p>This year they have a quality goal to reduce facility acquired pressure injury by 25% from 2016. And also reduce facility acquired skin tears by 25% from 2016. The first quarter they are on track to meet their pressure area reduction and have reduced by 50%. Skin tears, have not yet improved and the service is currently focusing on the care and attention to fingernails of both residents and staff, as they have found that long or sharp nails contributes to the skin tear occurrence.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Sixteen 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><b>Standard 1.2.1: Governance</b></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>Bupa Te Whanau Rest Home &amp; Hospital provides hospital (geriatric and medical) and rest home level care for up to 65 residents. There were 23 rest home level residents including one on respite and 27 hospital level residents in the hospital/rest home units including one younger person with disability (YPD) and three funded by ACC. There are 10 dual-purpose beds.</p> <p>A vision, mission statement and objectives are in place. Progress towards the achievement of annual goals for the facility have been reviewed by the care home manager. The annual goals for 2017 have been developed and communicated to staff (link 1.2.3.6).</p> <p>At the time of the audit, the care home manager was on leave. The service was being managed by a Bupa relieving care home manager who is a registered nurse with 16 years' experience of managing Bupa aged care facilities. She is supported by a clinical manager/registered nurse (RN) who has been employed at the facility for six months. The current clinical manager was working out her notice after resigning and a new clinical manager was undergoing orientation at the time of the audit. The care home manager and clinical manager are supported by a Bupa regional manager.</p> <p>The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p><b>Standard 1.2.2: Service Management</b></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>During the temporary absence of the care home manager, the clinical manager covers the care home manager's role with the support of the regional manager and the care home managers from other Bupa sites located in the mid central region.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>PA Low</p>	<p>Quality and risk raw data is reported across three monthly facility meetings and to the Bupa regional manager. Discussions with the managers and staff reflected staff do not feel well informed about quality outcomes. There has been one resident meeting in 2017 year-to-date.</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</p>

<p>principles.</p>		<p>policy are communicated to staff.</p> <p>The monthly collection 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. Data is provided to head office for benchmarking. Corrective action plans are developed when service shortfalls are identified. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. The 2016 resident/relative survey demonstrated overall satisfaction with the service. Corrective action plans were developed and implemented around activities and the food service.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Health and safety was evidenced to be consistently discussed as an agenda item in staff meetings. One health and safety representative was 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 identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats and use of low beds.</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. Sixteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations are conducted for unwitnessed falls. Data collected on incident and accident forms are linked to the quality management system.</p> <p>The relieving care home manager and clinical manager are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided. When a category one (serious) incident occurs, this is reported to head office who then undertake notifications to the required authorities. Notifications have been made around pressure injuries (six), an interruption in medical services, a failure of the call bell system, an unexpected death and a norovirus outbreak.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one registered nurse (RN), one clinical manager, three caregivers, one activities coordinator, one cook and one cleaner) included a recruitment process</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>(interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing 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.</p> <p>In 2016 72% staff attendance to compulsory education increased from 10% in 2015. There are two careerforce assessors, 19% caregivers are enrolled in careerforce and are working through these level 2 or 3; 63% of care staff have completed qualification, either level 2,3, core competencies or a course and 13% of caregivers have completed careerforce dementia modules.</p> <p>Over 80% have attended palliative care education</p> <p>Registered nurses are supported to maintain their professional competency. Six registered nurses are employed including the care home manager and clinical manager, and four have completed interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication, catheter care, wound management and syringe driver competencies. All RNs have attended palliative training and have participated in the SEQUAL project with hospice.</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>PA Low</p>	<p>There is an organisational staffing policy that includes skill mixes. There is a care home manager Monday – Friday and a clinical manager (RN) Monday – Friday. RN cover is provided 24 hours a day, seven days a week with one registered nurse at all times. RNs are supported by insufficient numbers of caregivers. Caregivers are not always replaced when staff are absent and staffing had not been increased when acuity was higher. Separate laundry and cleaning staff are employed seven days a week.</p> <p>Interviews with staff identified that staffing in the hospital wings, but not the rest home is adequate to meet the needs of residents.</p> <p>Staffing is as follows:</p> <p>Hospital wing one (currently eight hospital and three rest home level residents): two caregivers on duty from 7am to 3pm, one from 3pm to 11pm and one from 3pm to 10pm.</p> <p>Hospital wing two (currently 11 hospital and 2 rest home level residents): one caregiver from 7am to 3pm, one from 7am to 1.30pm, one from 3pm to 11pm and one from 3pm to 9pm.</p> <p>Rest home wing (currently 18 rest home level and 8 hospital level residents): two caregivers from</p>

		<p>7am to 3pm, one from 7am to 1.30pm, one from 3pm to 11pm, one from 3pm to 10pm and one from 4pm to 10pm.</p> <p>Two caregivers support the registered nurse overnight and cover all areas of the facility</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<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 by being held securely in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrate service integration with only medication charts and wounds held in separate folders.</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>There are overarching Bupa policies and procedures to safely guide service provision and entry to services, including an admission policy. Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The admission agreement reviewed aligns with the service's contracts. Eight admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.</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>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge, was documented in progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	PA Low	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. An RN checks all medications on delivery against the medication and any pharmacy errors recorded and fed back to the supplying pharmacy. All medications were securely and appropriately stored. The medication fridge temperature has been recorded daily and these were within acceptable ranges.</p>

<p>requirements and safe practice guidelines.</p>		<p>Registered nurses and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Caregivers who act as second checker have also completed medication competencies. The service uses an electronic medication management system.</p> <p>Sixteen medication charts were reviewed (eight rest home, eight hospital). Photo identification and allergy status were on all sixteen charts. All medication charts had been reviewed by the GP at least three-monthly. Not all resident medication administration signing sheets corresponded with the medication chart around giving of dietary supplements.</p> <p>There were no residents self-administering medications at the time of audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen manager oversees the food services and is supported by kitchen staff on duty each day. The national menus have been audited and approved by an external dietitian. The main meal is at lunch time. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in a bain-marie to each kitchenette where they are served. The kitchen manager receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated.</p> <p>End cooked food temperatures are recorded on each meal daily. Serving temperatures from a bain-marie are monitored. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained.</p> <p>Food services staff have complete on-site food safety education and chemical safety.</p> <p>Last year they focussed on their meals as they had significant feedback in both their resident survey and resident's meeting about the evening meal in particular. They went to the residents for a vote on changing their main meal to the evening; beginning May 2016 they changed their main meal and pudding to the evening. They reviewed this with residents at their meeting in July and the general vote was to keep with the change as most were happier with this option.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is</p>	<p>FA</p>	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this to residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential</p>

declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.		residents would be referred back to the referring agency if entry were declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The facility has embedded the interRAI assessment protocols within its current documentation. Bupa assessment booklets on admission and care plan templates were completed for all the resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all files. Files reviewed across the service identified that risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation. Additional assessments for management of behaviour, wound care and restraint were completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into care plans (link 1.3.5.2).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	All resident care plans sampled documented support needs and interventions, however not all care plans were updated as resident status changed. Residents and family members interviewed confirm they are involved in the development and review of care plans.  Short-term care plans were in use for wounds and infections and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents and families interviewed reported their needs were being met. There was documented evidence of relative contact.  Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.  Wound assessment, wound management and evaluation forms and short-term care plans were in place for all wounds. All wound care plans included a short-term care plan and written progress notes to assist review and evaluation of the wound.  There were two unstageable pressure injuries and one stage-3 pressure injury being treated at the time of audit. Evidence of GP, dietitian, physiotherapist, and wound care nurse specialist input into

		<p>wound care was documented in resident files. Recommendations made were evidenced to be implemented. However, not all recommendations were updated into the long-term care plan (link to 1.3.5.2).</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. Monitoring of enablers when in use was not evidenced to be completed as per Bupa policy (link 2.2.3.4).</p> <p>The service has been working on weight loss management since last surveillance audit with a system in place where the night RN charts all weight recordings and then completes a short term care plan and completes appropriate referral to GP and/or dietitian. The clinical manager signs off the weight record for each month ensuring the appropriate actions have been taken for those resident required (link 1.3.5.2).</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 team is led by an experienced diversional therapist who works 35 hours per week, Tuesday to Saturday.</p> <p>The integrated programme for rest home and hospital level of care residents takes place in both areas. There are resources available for care staff to use for one-on-one time with the resident. The younger resident interviewed stated their recreational and social needs were met.</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 and a record is kept on individual resident's activities. There are recreational progress notes in the resident's file that the diversional therapist completes for each resident every month. 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.</p> <p>The facility has a van which is used for outings. The diversional therapist and a care giver accompany residents on outings. The diversional therapist has a current first aid certificate.</p> <p>Families and resident reported that there had been an improvement in the variety of activities provided in the last six months. Residents were observed to be provided with and enjoying a wide range of activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans</p>	FA	<p>Care plans reviewed had been evaluated by registered nurses' six monthly. The multidisciplinary review involves the RN, GP, physiotherapist, diversional therapist and resident/family. The family are</p>

<p>are evaluated in a comprehensive and timely manner.</p>		<p>notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p> <p>Written evaluations describe the resident's progress against the residents identified goals. 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 (link 1.3.5.2).</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>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed and the resident was reassessed for a higher or different level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, Bupa specialists and contracted allied services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, 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 sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness certificate is posted at the entrance to the facility which expires 25 August 2017.</p> <p>Reactive maintenance and a 52-week planned maintenance schedule is in place that has been maintained. There is a maintenance person employed, who works three days per week and provides after hours on-call cover for any maintenance issues. The maintenance person has completed stage-1 health and safety training. The hot water temperatures are monitored weekly and maintained between 43-45 degrees Celsius. There are contractors for essential service available 24/7.</p> <p>The corridors are wide with handrails and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids</p>

		<p>where required.</p> <p>The external areas are well maintained. There is outdoor furniture and shaded areas. There is wheelchair access to all areas.</p> <p>The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care.</p> <p>A refurbishment of some bedrooms and the small south lounge has been commenced, doing bedrooms as they become vacant.</p> <p>A garden beautification programme has been implemented. The maintenance man &amp; a keen gardener (resident) has been planting in the gardens &amp; pots throughout the grounds for the pleasure of the residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of communal toilets located near to bedrooms and the communal areas. Bathrooms are spacious and can accommodate the use of a shower trolley and any mobility equipment. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Residents interviewed reported their privacy is maintained at all times.</p> <p>Privacy locks are installed on all toilet and shower doors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The majority of rooms are single. There are three double rooms which have privacy curtains between bed spaces. Rooms are spacious enough to manoeuvre transferring and mobility equipment to safely deliver care. There are 18 dedicated rest home beds and 47 hospital beds. Ten of the hospital beds are dual-purpose which can be used to provide rest home or hospital level care. Residents are encouraged to personalise their bedrooms as desired</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	FA	<p>There are lounges in the hospital and rest home area. Each area also has a kitchenette and open plan dining area. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. 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.</p>

<p>accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is completed on-site. There are designated clean and dirty areas in the laundry with separate entrance and exit doors. Laundry and cleaning audits are completed as part of the internal audit programme. The laundry and cleaning rooms are designated areas and clearly labelled. Chemicals are stored in locked rooms. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended.</p> <p>There are dedicated cleaning and laundry staff. Cleaning trolleys are well equipped and stored safely when not in use. Residents and relatives interviewed reported 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>	<p>FA</p>	<p>An approved fire evacuation plan is in place. There are emergency management plans to ensure health, civil defence and other emergencies are included. Fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity or a sensor mat was in place where required. Staff were observed to answer call bells promptly including responding to an emergency bell which rang on day one of audit.</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</p>	<p>FA</p>	<p>The temperature in individual resident rooms is able to be adjusted to meet resident's preference or seasonal changes. All communal rooms and bedrooms are well ventilated and light. Residents and family interviewed stated the temperature of the facility is comfortable.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control officer is a registered nurse (the clinical manager) and she is responsible for infection control across the facility. The committee and the Bupa governing body are responsible for the development of the infection control programme and its review. The infection control programme is established at Bupa Te Whanau. The infection control committee consists of a cross-section of staff and there is external input as required from general practitioners and the Bupa quality &amp; risk team. There has been one outbreak since the previous audit. The outbreak was contained to the rest home area and lasted from 12 June 2017 to 6 July 2017. As the outbreak had only recently been resolved, an evaluation had not been completed at the time of the audit.</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>	FA	<p>There are adequate resources to implement the infection control programme at Bupa Te Whanau. The infection control (IC) officer has maintained best practice by attending an infection control boot camp through Bug Control in August 2016. The infection control team is representative of the facility. External resources and support are available through the Bupa quality &amp; risk team when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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>	FA	<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 relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held, including (but not limited to) handwashing, outbreak management, and infection prevention &amp; control and standard precautions.</p> <p>The infection control officer has access to the Bupa intranet with resources, guidelines best practice and group benchmarking.</p> <p>A number of toolbox talks have been provided including (but not limited to) outbreak management.</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.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and the Infection Control Practitioner at the DHB that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Effective monitoring is the responsibility of the infection control officer. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff.</p> <p>Infections statistics are included for benchmarking. Corrective actions are established where trends are identified.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Moderate</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 confirmed their understanding of restraints and enablers. However, restraint and an enabler were in use that were not identified as such.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. At the time of the audit, the service had two residents identified as requiring the use of two restraints and three with documented enablers. Enabler use was voluntary for two of these residents. The other was not competent to express consent.</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>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator and for staff are documented and understood, confirmed in interviews. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</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>	<p>FA</p>	<p>A restraint assessment tool had been completed for residents identified by the service as requiring an approved restraint for safety (link 2.1.1.4). Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau were evident. Two files of residents using restraint (one t-belt and one bed rail) were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>Procedures around monitoring and observation of restraint and enabler use are documented in policy but not always documented as implemented for residents with enablers. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint is linked to the resident's restraint care plan and two care plans reviewed reflected the risks associated with the use of a t-belt and bed rail when in use. An internal restraint audit monitors staff compliance in following restraint procedures (link 2.1.1.4).</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Consistent evidence to verify two hourly checks was sighted on the monitoring forms for two residents requiring the use of a restraint. Documentation of monitoring for enablers as required by policy was not consistently completed.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers. Not all residents with restraint or enabler were included</p>

		on the registers (link 2.1.1.4).
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted three-monthly, evidenced in two resident files where restraint was in use. Restraint use and the evaluation of the continuing need for restraint of each resident was evidenced discussed in the RN meeting minutes reviewed (link 1.2.3.6).</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>	FA	<p>The Bupa restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	There is a documented meeting schedule with meetings occurring at various intervals. Most are two-monthly, but these have not always occurred regularly.	Despite recurring issues all facility meetings except restraint have only occurred three-monthly. Staff report not feeling well informed. The service has remained consistently above benchmarks in several areas through late 2016 and 2017 YTD. Corrective action plans, focussing on individual residents have not been reviewed and updated despite being ineffective.	Ensure meetings are held at a frequency to ensure that issues are promptly addressed and that staff are well informed. Where quality data is evaluated and corrective actions initiated;

				ensure these are reviewed for effectiveness and amended where needed.  60 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Bupa Te Whanau has a roster where all staff are rostered to various shifts and specific area. The roster does not provide adequate cover of caregivers in the rest home. There are four casual caregivers employed and staff and management reported that agency staff are not used. Absent staff are frequently not replaced as sighted on the roster and confirmed by staff. There was no evidence of staffing being increased when acuity increases.</p>	<p>(i) The 'rest home' (which includes eight hospital level residents) as evidenced by staff interviews and review of the roster does not always include sufficient staff to support the needs of residents. (ii) When illness or leave create gaps in the roster, staff are frequently not replaced. (iii) When acuity increases there is no evidence of an increase in staffing. This was particularly evident during the recent protracted outbreak. (iv) During the recent outbreak, when the rest home (which also houses hospital level residents) was fully isolated and locked down there was no registered nurse rostered to cover this isolated area.</p>	<p>Ensure there is sufficient staff with a correct skill mix to meet resident's needs at all times.</p> <p>30 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and</p>	PA Low	<p>The service uses an electronic medication management system. Twelve of sixteen</p>	<p>Four medication charts and signing sheets reviewed of residents prescribed a dietary supplement, evidenced gaps in electronic</p>	<p>Ensure dietary supplements are documented</p>

guidelines.		electronic medication signing charts reviewed aligned with the medication chart.	medication signing sheets where the supplement had not been administered as prescribed.	as administered as prescribed.  30 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	Four rest home and four hospital level care plans were reviewed. All eight care plans had care plans that included most of the assessed needs; however, hospital care plans reviewed had not been updated to include changed resident needs.	<p>Not all care plans reviewed included interventions to address all resident needs or had not been updated to reflect interventions currently being implemented.</p> <p>(i) One hospital file reviewed did not document management of constipation, or pain management;</p> <p>(ii) One hospital ACC resident file reviewed had not been updated to reflect changes to continence (no longer has a catheter), and the need for use of lap belt restraint when in specialist wheelchair. For the same resident, with a current unstageable pressure injury, this was not documented in care plan, and pressure injury prevention equipment currently in place (air wave mattress) was not documented in the care plan;</p> <p>(iii) For a hospital resident with 7% weight loss in one month; the care plan had not been updated to reflect interventions being implemented to manage weight loss. The prescribed dietary supplement was not evidenced to be administered as prescribed (link to 1.3.12.6); and</p> <p>(iv) In two of two restraint files</p>	<p>Ensure care plans are updated as resident need changes.</p> <p>60 days</p>

			sampled the management of the risks associated with restraint use were not documented.	
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Moderate	Staff complete restraint training and competencies annually. Staff interviewed where able to describe the processes required for restraint to be implemented. Despite this there were residents restrained and with an enabler that were not approved or documented.	(i) During a tour of the facility a resident who is not assessed for an enabler had bed rails up on the bed. (ii) One resident with a lap belt on a wheelchair had not had this identified as a restraint. (iii) One resident who is not competent to consent to an enabler has a bed rail documented and managed as an enabler, not a restraint.	<p>Ensure that restraints are only used when the resident has been assessed and the restraint approved. Ensure that bed rails on beds are not raised when the resident is not approved for a restraint or enabler.</p> <p>30 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered,</p>	PA Low	Bupa policy dictates that residents using enablers must be regularly monitored and that the monitoring should be documented in the progress notes. This was not regularly occurring.	The two resident files sampled for residents with enablers did not consistently have monitoring documented in the progress notes.	<p>Ensure Bupa policies are implemented around documenting monitoring of residents with enablers.</p> <p>90 days</p>

<p>provided or facilitated;  (d) The outcome of the restraint;  (e) Any injury to any person as a result of the use of restraint;  (f) Observations and monitoring of the consumer during the restraint;  (g) Comments resulting from the evaluation of the restraint.</p>				
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.