

Bupa Care Services NZ Limited - St Andrews Care Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	St Andrews Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 August 2017 End date: 10 August 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:	40

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

St Andrews Care Home is part of the Bupa group. The service is certified to provide rest home and hospital (medical and geriatric) level care for up to 40 residents. On the day of audit there were 40 residents.

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

The care home manager has been in the role since the facility opened. She is supported by a clinical manager who has over five years experience in clinical management roles at another Bupa facility.

There are quality systems and processes being implemented that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to St Andrews. Quality initiatives are being implemented, which provide evidence of improved services for residents. There is an orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

Two improvements have been identified around neurological observations and documentation of controlled drugs.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		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 the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. St Andrews 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. Quality and risk

performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes, quality action forms and toolbox talks, demonstrate a culture of quality improvements. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. The staffing levels meet contractual requirements. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

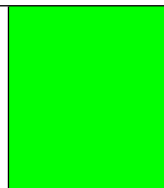
Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. A sampling of residents' clinical files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme.

Individual activities are provided either within group settings or on a one-on-one basis. Staff responsible for medication management had current medication competencies. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. There is a large well-equipped kitchen and the kitchen manager/chef oversees provision of the food service. All kitchen staff have completed food safety training.

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.



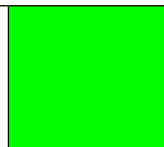
Standards applicable to this service fully attained.

The service provider's documentation evidences appropriate (reactive and planned maintenance) systems are in place to ensure the consumers' physical environment and facility is maintained. There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals were stored safely throughout the facility and there is appropriate protective equipment and clothing for staff. Material safety datasheets are available.

Housekeeping staff maintain a clean and tidy environment. There is a large well-equipped laundry area with separate clean and dirty rooms. There is a system in place to manage soiled linen appropriately and safely. The facility is appropriately heated and ventilated. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty at all times.

Restraint minimisation and safe practice

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



Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. At the time of the audit, the service had no residents using restraints or 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.

St Andrews has an infection control programme that complies with current best practice. The infection control manual outlines a 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. There is a dedicated infection control nurse who has a role description with clearly defined guidelines. The infection control programme is reviewed annually at organisational level.

The infection control programme is designed to link to the quality and risk management system. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided includes an evaluation of the session and content delivered. Records of all infections are kept and provided to head office for benchmarking.

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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with seven care staff (three caregivers, two registered nurses and two activity coordinators), 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 seven resident files reviewed. General consent forms were evident in the seven 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 (EPOA) 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 treatment.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</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>	<p>FA</p>	<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 are able to participate in as much as they can safely and desire to do. Resident meetings are held monthly and relative meetings bi-monthly. Monthly newsletters are provided to residents and relatives.</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>	<p>FA</p>	<p>The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint's register. Seven complaints received in 2017 were reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Code. Any corrective actions developed have been followed-up and implemented. Two complaints made through the local district health board (DHB) in 2017 were investigated and any corrective actions required have been fully followed-up. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<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, clinical manager and registered nurses (RN) discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Seven residents (six rest home level and one hospital level) and four relatives (three rest home and one hospital) interviewed, report that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>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 received training in July 2017.</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. At the time of the audit there was one resident who identified as Māori living at the facility. Māori consultation is available through the documented iwi links and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic, last occurring in June 2017. 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. All care plans reviewed included the resident's social, spiritual, cultural and recreational 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>Standard 1.1.8: Good Practice</p>	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. A house general practitioner (GP) visits the</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>facility one day a week. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The service receives support from the local district health board (DHB). Physiotherapy services are provided on-site, four hours per week. 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 has established benchmarking groups for rest home, hospital, dementia, psychogeriatric/mental health services. St Andrews is benchmarked against the rest home and hospital data. If the results are above the benchmark, a corrective action plan is developed by the service. All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidence-based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<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. 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. Fourteen accident/incident forms reviewed from July 2017, 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. The information pack is available in large print and is read to residents who require assistance. 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>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>St Andrews Care Home is part of the Bupa group of care homes and is situated in Hamilton. The care home is a purpose-built single level facility which opened on 25 October 2016. The service currently provides care for up to 40 residents. All 40 beds are dual-purpose (hospital and rest home). At the time of the audit there were 40 residents, 10 hospital residents and 30 rest home residents. There were two rest home residents on respite. All other residents were under the Aged Related Residential Care (ARRC) contract.</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been</p>

		<p>determined, which link to the overarching Bupa strategic plan. St Andrews is part of the Midlands Bupa region and the managers from this region meet bi-monthly to review and discuss the organisational goals and their progress towards these. The operations manager teleconferences monthly and completes a report to the director of care homes and rehabilitation. St Andrews has set a number of quality goals around the opening of the care home and these also link to the organisations quality and health and safety goals. A quarterly report is prepared by the care home manager and sent to the Bupa continuous service improvements (CSI) team on the progress and actions that have been taken to achieve the St Andrews quality goals.</p> <p>The care home manager has been in the role since the facility opened and has previous experience as a clinical manager and care home manager with Bupa in New Zealand and in the United Kingdom. She is supported by a clinical manager who has over five years' experience in clinical management roles at another Bupa facility. Staff spoke positively about the support/direction and management of the current management team. The operations manager supports the management team and was present during the days of the audit.</p> <p>The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical manager steps in when the care home manager is absent. The operations manager who visits regularly, supports the clinical manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management system has been established on opening and implemented. Quality and risk performance is reported across facility meetings and to the operations manager. Discussions with three managers and staff reflected staff involvement in quality and risk management processes. 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. Policies are regularly reviewed through head office. 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 injuries, wounds and</p>

		<p>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 developed when service shortfalls are identified and signed off when completed. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements.</p> <p>Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee. 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 (Smile) is in place, which is linked to the overarching Bupa National Health and Safety Plan. There was an annual resident/relative satisfaction survey completed in June 2017 with a 92% overall satisfaction rate.</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 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>	PA Low	<p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Fourteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. However, not all neurological observations were completed for resident falls that resulted in a potential head injury. Incidents are benchmarked and analysed for trends. The managers are aware of their requirement to notify relevant authorities in relation to essential notifications.</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</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files (one clinical manager, one RN, two caregivers, one kitchen manager/chef and one maintenance officer) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g., RN,</p>

<p>of legislation.</p>		<p>support staff) and includes documented competencies. Newly employed caregivers complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they will have attained their first national certificates. From this, they are then able to continue with Core Competencies Level 3, unit standards. These align with Bupa policy and procedures.</p> <p>There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. Education and training for clinical staff is linked to external education provided by the DHB. There are five RNs and four have completed interRAI training. Core competencies are completed annually and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). There are a number of implemented competencies for registered nurses including insulin administration, moving & handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, syringe driver and 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 staffing levels meet contractual requirements. The care home manager and clinical manager are available during weekdays. The care home manager is on-call after hours for any organisational concerns and the clinical manager is on-call for any clinical issues. Adequate RN cover is provided 24 hours a day, seven days a week. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes and meet best practice. The RNs are supported by five caregivers on duty on the morning shift, four caregivers on the afternoon shift and two caregivers on the night shift. Interviews with residents and family members identify that staffing is adequate to meet the needs of residents.</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>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent,</p>	<p>FA</p>	<p>The service has admission policies and processes in place. Prior to entry all potential residents have a needs assessment completed by the needs assessment and coordination service to assess suitability for entry to the service. Residents receive an information pack outlining information about:</p>

<p>equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>St Andrews, the services able to be provided, the admission process and entry to the service. The care home manager screens all potential residents prior to entry and records of all admission enquiries are kept in an electronic system.</p> <p>Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the care home manager or clinical manager. The admission agreement form in use aligns with the requirements of the ARRC contract and includes clause A13. All admission agreements sighted (five rest home and two hospital) on the day of audit are signed. Residents (six rest home and one hospital) and relatives (one hospital and three rest home) interviewed, stated they were informed of clause A13 prior to admission.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>Prescribed medications are delivered to the facility and checked on entry by the RN. Medications were appropriately stored with medicines stored in original dispensed packs. The controlled drug register documented weekly checks and six-monthly physical stocktakes. However, at time of audit it was noted the controlled drug (CD) register was not always maintained. The fridge temperatures are conducted and recorded daily. All staff (RNs and senior caregivers) authorised to administer medicines have current competencies.</p> <p>There is an electronic medication management system in place. All staff administering medications had completed training for the electronic system. Medication rounds were observed and evidenced good practice according to policy. Administration records are maintained, as are staff specimen signatures. There was evidence of compliance around medication prescribing. There were two rest home residents who self-administer medications and both had three-monthly competencies checked, signed by the GP and a record kept on file.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p>	<p>FA</p>	<p>There is a fully equipped purpose-built kitchen and all food is cooked on-site. Food service provision is overseen by a qualified chef with many years' experience in the food industry. A second cook and kitchenhand provide cover across seven days per week. There is a food-services manual in place to guide staff. The chef advised that a resident nutritional profile is developed for each resident on</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>admission; all nutritional profiles were available in the kitchen for all residents. The nutritional profile is reviewed at least six-monthly as part of the care plan review and the kitchen is notified of any changes as they are identified. The kitchen is able to meet the needs of residents who require special diets and the chef works closely with the RNs on duty. Kitchen staff were aware of specific resident needs (on wall in kitchen in a private location) including but not limited to food allergies, diabetic diets.</p> <p>All kitchen staff had completed food safety training. Cleaning schedules are evident and maintained. The chef interviewed is knowledgeable about resident individual needs and stated he sources daily feedback from residents regarding their individual likes and dislikes. The chef stated he manages weight loss with the RNs and has introduced initiatives to support weight management. Scrambled eggs are on offer daily at breakfast. Fresh fish is served as per menu. The chef takes all resident orders a day ahead and there are up to as many as four options offered as per premium room offer. There is information given about the food service on offer prior to admission. The kitchen follows a four-weekly rotating seasonal menu, which is reviewed annually by a dietitian (at organisational level).</p> <p>Refrigerators, freezers and cooked food temperatures are monitored and recorded. Kitchen 'air conditioning temperatures' are recorded daily. All food is stored appropriately. Food is delivered straight to the main dining room and a tray service is available and delivered via a hot box to resident rooms upon request. Residents and the family members interviewed confirmed they were provided with lunch and dinner options prior to admission and a day ahead, which was in-line with the premium room services offered. There is a 'compliments and suggestions register' which evidences daily (sometimes written notes) feedback from residents and families. Residents and relatives stated they were very happy with the high quality, presentation and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred to the needs assessment service or referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	<p>FA</p>	<p>The facility has embedded the interRAI assessment protocols within its current documentation. Risk assessments and care plan templates were completed and were detailed for all the resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all long term resident files. Six long-term resident files reviewed across the rest home and hospital identified that risk assessments have been completed on admission and reviewed six-monthly as part</p>

manner.		of the evaluation (one was respite). Additional assessments for management of behaviour, pain and wound care were appropriately completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into the care plans in the resident files.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>All resident care plans sampled were resident centred and support needs were documented in detail in the resident file. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations and they are involved in the care planning and review process. The interRAI assessment process informs the development of the resident's care plan. Short-term care plans are in use for changes in health status, are signed off once completed or transferred to the long term care plan.</p> <p>Caregivers interviewed reported they accessed the resident file to review care plans and write progress notes and they found the care plans easy to follow. One rest home resident identified as high falls risk had a specific falls management plan to keep them safe from falling. Other specific care plans were implemented for specific health needs, including (but not limited to) medical needs, diabetes, pressure injury management and prevention and wounds.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Registered nurses and caregivers, follow the care plan in the resident file and report progress against the care plan at handovers. If external nursing or allied health advice is required, the RNs will initiate a referral (district nurse [hospice nurse], mental health or other specialist nurses). If external medical advice is required, this will be actioned by the GP. Caregivers and RNs interviewed state there is adequate equipment provided, including continence and wound care supplies. Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Wound care plans, behaviour plans, pain management and specific resident plans (bowel management) are evident.</p> <p>It was noted that call bells were within reach and sensor mats appropriately placed and switched on. Residents were observed to be well dressed including shaves as needed.</p> <p>Wound management plans were fully documented for all current wounds; wound re-assessment and rationale for when changes were made to the wound plan were fully documented with each dressing change. There were fourteen wounds present on the day of audit. There were no pressure injuries on the day of audit. There were nine skin tears and five skin lesions. All wounds have been assessed and reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the DHB wound care nurse specialist if required. Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of</p>

		residents. Care plan interventions were detailed and appropriate to assessed needs. A restraint free environment was promoted and there were no residents with restraint or enabler at time of audit.
<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 service employs an activities coordinator (ten hours per week) and an activities assistant (thirty hours per week) who deliver the activities programme across seven days per week. The programme provides activities that are meaningful and relevant for all residents. Time is spent with residents and families to further explore their individual life goals and to aid development of new and meaningful activities. Rest home and hospital residents join together for the activity programme. Participation of residents is monitored and documented. There are strong links with community. Village residents participate in some of the activities and celebrations on offer. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All residents in the facility may choose to attend any of the activities offered. Daily contact is made and one-on-one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme.</p> <p>Volunteers (two students) are involved in the activities programme. There are regular van outings for all residents (as appropriate), regular entertainment and involvement in community. Some residents go out to the local knitting group. The activity programme is developed a week in advance and a calendar is displayed throughout the facility. The activity plans reviewed were documented well and reflected the residents' preferred activities and interests. Each resident has an individual activities assessment on admission and from this information an individual activities care plan is developed. The activities plans were reviewed six-monthly as part of the MDT meeting with nurses, the activity staff and families. Residents and families interviewed stated they enjoy the variety of activities offered and they have input into planning of the programme via daily feedback, resident surveys and at resident meetings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans were evaluated by the RN within three weeks of admission. Care plans reviewed had been evaluated by registered nurses six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The GP reviews residents at least three-monthly or when there is a change in health status. The family members interviewed confirmed they are invited to attend the GP visits and multidisciplinary care plan reviews.</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>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Discussions with registered nurses identified that the facility has direct access to services including DHB nurse specialists, podiatrist and physiotherapy (contracted) 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>	FA	<p>There are policies in place to guide staff in waste management. All 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 were stored safely throughout the facility. Safety datasheets 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>	FA	<p>The facility is purpose built and is spacious. The care home has a total of 40 hospital (medical and geriatric) and rest home (all dual-purpose) rooms. All bedrooms are single occupancy (eight shared ensuites and twenty-four rooms have their own ensuite). All rooms and ensuites have been designed for hospital level care and premium level care. There is a mobility bathroom with shower available. Shared ensuites have locks and green/red lights to identify occupied. These can be opened if necessary by staff in an emergency. There are handrails in ensuites, communal bathrooms and hallways. All rooms and communal areas allow for safe use of mobility equipment. The facility is carpeted throughout with vinyl surfaces in bathrooms/toilets and kitchen areas. There are three visitor toilets with adequate handwashing facilities.</p> <p>There are two nurses' stations located with windows (one opening out in to the main dining room and the other opening out in to the main lounge. Internal and external areas are safe and easily accessible for residents and family members. There is a large landscaped internal courtyard area that the main lounge, smaller lounge, café and main dining room open out to. Residents are able to move freely in and around the facility. Staff stated they had sufficient equipment (including personal equipment to support individual needs) to safely deliver the cares as outlined in the resident care plans for all people receiving services. The building has a current building warrant of fitness which expires on 3 March 2018. There is a maintenance officer employed full time to address the reactive</p>

		<p>and planned maintenance programme. All reactive maintenance had been completed.</p> <p>All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals were stored safely throughout the facility and there is appropriate protective equipment and clothing for staff.</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 is a mobility toilet near the main lounge and one near the dining room. Each resident room has either a shared ensuite or single ensuite. All ensuites throughout the facility have been designed for hospital level care and allows for the use of mobility equipment. Shared ensuites have locks and green/red lights to identify they are occupied. The opposite door in the shared ensuite automatically locks when in use (interlocking). These can be opened if necessary by staff in an emergency. There is a mobility bathroom with shower bed available.</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>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</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>	FA	<p>The service has a main lounge, a large separate dining area, a café and a second smaller lounge area. The lounges, dining room and café are accessible and accommodate the equipment required for the residents. The lounges and dining areas are large enough to cater for activities. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit.</p>
<p>Standard 1.4.6: Cleaning And</p>	FA	<p>There are cleaning policies and processes. The cleaner's cupboards are designated areas and are lockable for storage of chemicals. All chemicals are labelled and stored securely. Cleaning and</p>

<p>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>laundry audits occur as per the internal audit system. Corrective actions required are followed through the quality/health and safety as well as all staff meetings. There is a large laundry with separate clean and dirty rooms. There is a laundry manual that contains (but is not limited to) safety, standard infection control practises, procedures for the laundry of linen, infected linen, a laundry flow chart, sluicing soiled laundry, washing, drying, the cleaning of the laundry and chemical safety and storage. The laundry and cleaning room are designated areas and clearly labelled. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. Residents interviewed were satisfied with the standard of cleanliness in the facility and with the current laundry services.</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>There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. The facility has an approved fire evacuation scheme dated 3 October 2016. Fire evacuation drills take place every six months, with the last fire drill occurring on 1 June 2017. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a back-up system for emergency lighting and battery back-up.</p> <p>There are civil defence kits in the facility that are checked six-monthly. There is sufficient water stored to ensure for three litres per day for three days per resident. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. Access by public is limited to the main entrance.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. The facility has central heating that is thermostatically controlled. All bedrooms and communal areas have at least one external window.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment,</p>	<p>FA</p>	<p>St Andrews has an infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Bupa KPIs. The clinical manager is the designated infection</p>

<p>which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>control nurse and has access to the DHB infection control nurse and microbiologist. Audits have been conducted and include hand hygiene, infection control practices in the laundry and cleaning service. Education is provided for all new staff on orientation. Staff interviewed stated they had adequate supplies of personal protective equipment (PPE). The infection control programme is reviewed annually by the corporate quality and risk team.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The clinical manager is the infection control nurse and is aware of the need to analyse data and the reasons behind this. The infection control nurse receives ongoing education and completed Bug Control training in September 2016. In the event of the infection control nurse requiring advice this is available through the GP, the DHB resource person or Bug Control.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation and uses references where appropriate.</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 nurse ensures training is provided to staff. Informal education is provided, availability of the education was confirmed by caregivers interviewed. The orientation package includes specific training around hand washing and standard precautions. Training on infection control occurred in July 2017. Hand washing is an annual competency. Resident education is expected to occur as part of providing daily cares.</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 nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and laboratory that advise and provide feedback/information to the service.</p> <p>Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control nurse. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.</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. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. At the time of the audit, the service had no residents using restraints or enablers. Staff training around restraint minimisation and management of challenging behaviours has been scheduled for September 2017.</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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Fourteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. However, not all neurological observations were completed for resident falls that resulted in a potential head injury.</p>	<p>Fourteen incident forms were reviewed in total. Six incident forms were reviewed for resident falls with a head injury. The neurological observations forms were not all fully completed for these six incidents.</p>	<p>Ensure that neurological observations forms completed for any resident fall with a head injury are fully completed.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>Electronic medicine charts evidenced residents' photo identification, recorded allergies and three-monthly medicine reviews. The residents' medicine charts recorded all medications each resident was taking (including name, dose, frequency and route to be given). Fourteen medication charts were reviewed: Ten rest home and four hospital. There is one CD cupboard where medicines are stored appropriately and safely. All staff who administer medicines have completed annual competencies. A shortfall was identified around maintenance of controlled drug register documentation.</p>	<p>The controlled drug register did not document the controlled drug count or signatures (two staff) for one rest home resident administered controlled drugs.</p>	<p>Ensure the controlled drug register is maintained accurately and in a timely manner for any CD medication given.</p> <p>30 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.