

Bupa Care Services NZ Limited - Windsor Park Specialist Senior Care Centre

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:	Windsor Park Specialist Senior Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 21 August 2017 End date: 22 August 2017
Proposed changes to current services (if any):	To utilise 10 hospital rooms as dual-purpose (rest home and hospital)
Total beds occupied across all premises included in the audit on the first day of the audit:	62



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

Windsor Park Care Home is part of the Bupa group. The service is certified to provide rest home, hospital (medical and geriatric), dementia and residential disability (physical) level of care for up to 79 residents. On the day of audit there were 62 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, the 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 for the last three years. She is supported by an experienced clinical manager.

There are quality systems and processes being implemented that are structured to provide appropriate quality care for people who use the service, including residents that require hospital and rest home level care. Implementation is supported through the Bupa quality and risk management programme that is individualised to Windsor Park. 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.

The service has achieved two continuous improvement ratings relating to falls reduction, and the food service.

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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Windsor Park 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. 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. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

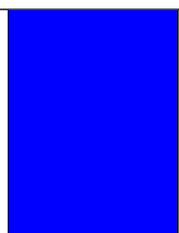
Organisational management

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.		Standards applicable to this service fully attained.
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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. Windsor Park 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/toolbox talks, demonstrated a culture of quality improvements. An annual resident/relative

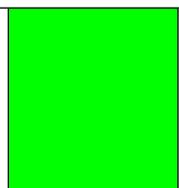
satisfaction survey is completed and there are regular resident/relative newsletters. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. The staffing levels meet the needs of residents. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>All standards applicable to this service fully attained with some standards exceeded.</p>
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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 sample of residents' 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 resident groups. The residents and family interviewed confirmed satisfaction with the activities programme. Staff responsible for medication management have 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.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe, secure and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. At the time of the audit, the service had four residents using restraints (four lap belts) and one resident with a lap belt as an enabler. Staff receive training in restraint minimisation and management of challenging behaviours. Assessed risks are documented in care plans. Ongoing restraint assessments, monitoring and evaluation occurs. The service and organisation regularly review restraint use and strive to minimise the use of restraint.

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.

Windsor Park has an infection control programme that complies with current best practice. The infection control manual includes a range of policies. 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 and links to the quality and risk management system. Infection control education is provided at orientation and incorporated into the annual training programme. Surveillance is undertaken and 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	1	49	0	0	0	0	0
Criteria	2	99	0	0	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. 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 seven care staff (four caregivers, two registered nurses and one diversional therapist), 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>There is an informed consent policy. In all eight files sampled, (two rest home, two dementia and three hospital [one of which was a resident on respite] and one younger person with a disability). All had general consent forms signed on file for van outings. Staff were knowledgeable around informed consent. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy.</p> <p>There was evidence in files sampled of family/EPOA discussion with the GP for a medically indicated not for resuscitation status. In the files sampled, there was an appropriately signed resuscitation plan and advance directive in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been</p>

		<p>signed and sighted for all the files seen.</p> <p>Copies of EPOA's were on resident files in the dementia unit.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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.</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 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. Quarterly newsletters are provided to residents and relatives.</p> <p>One of the YPD residents is supported to attend community groups including (but not limited to) the RSA.</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 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. Eight complaints made in 2016 and five complaints received in 2017 year to date were reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed has been followed up and implemented. 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>	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, 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. Nine residents (four rest home and five hospital level) and four relatives (three hospital and one</p>

		dementia care level) interviewed, reported 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>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 identified 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 August 2017.</p> <p>Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity and this could be described by staff.</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 were no residents that identified as Māori living at the facility. Māori consultation is available through the documented iwi links (Te Runanga O Ngāi Tahu) and Māori staff who are employed by the service. 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. 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,</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</p>

harassment, sexual, financial, or other exploitation.		training sessions, staff meetings, and performance management if there is infringement with the person concerned.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</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 facility for four hours, once 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 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 for eight hours once a week. 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. Windsor Park is benchmarked against the rest home, dementia 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 evidenced 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>The service has implemented (but not limited to) the following quality initiatives since previous audit; (i) introduction of resident and families' newsletters quarterly with recent activities and information on upcoming events. (ii) relationship with the SDHB wound specialist available for advice & support for any wound management issues; (iii) they are trialling a new initiative of monthly MDT meetings with Support of the Older Persons team and Community Mental Health team, with optional involvement of dietitian, Hospice and physiotherapist to discuss complex residents to develop plan of care and twice weekly clinical review meetings run by the clinical manager with qualified staff to discuss current resident's needs.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policies 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</p>

		<p>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. 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>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Bupa Windsor Park is certified to provide rest home, hospital (geriatric and medical), dementia and residential disability (physical) level care for up to 79 residents (one room was decommissioned). On the day of audit there were 62 residents, 26 rest home level residents including two residents on respite in the 29-bed rest home, 20 hospital level residents including three residents under younger persons with disabilities (YPD) contracts and two residents on respite in the 34-bed hospital and 16 residents in the 16-bed dementia unit. This audit also included verifying 10 hospital beds as suitable to provide dual-purpose level care (rest home and hospital).</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. Windsor Park is part of the Southern 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. Windsor Park has set a number of quality goals that 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 Windsor Park quality goals.</p> <p>Quality goals include (but not limited to); (i) To reduce manual handling incidents (noting YTD this has decreased by approximately 75%). (ii) Aiming to reduce facility acquired pressure areas by 50% from 2016 and (iii) Reduce falls rate by 20% from 2016.</p> <p>The service is managed by a registered nurse (RN) who has been the care home manager at Bupa Windsor Park for three years. She is supported by a clinical manager who has also been in the role for one and a half years (was previously the unit coordinator). Care home managers and clinical managers attend annual organisational forums and regional forums six-monthly. The operations manager visits monthly and more often if required. The operations manager was present during the audit. The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service including dementia level</p>

		care.
<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>	FA	<p>The clinical manager who is employed full time 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>	FA	<p>A quality and risk management system is being implemented into practice. Quality and risk performance is reported across facility meetings and to the organisation's management team. Discussions with the 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. 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 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, demonstrated 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 97% overall satisfaction rate. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of</p>

		interventions on a case-by-case basis to minimise future falls.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>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. Neurological observations were completed for resident falls reviewed that resulted in a potential head injury. Incidents are benchmarked and analysed for trends. The care home manager and clinical manager were able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	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 and completed orientation checklists. Staff performance appraisals were all completed and signed off on an annual basis. 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, support staff) and includes documented competencies. The caregivers when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, care staff have effectively 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. Ninety nine percent of the total of caregivers have attained a Career Force qualification. A total of 82% of staff have attained at least one Bupa Personal Best certificate.</p> <p>There are 17 caregivers who work in the dementia unit and all have completed the required dementia standards.</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 six 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>

		Staff training has included sessions on privacy/dignity, spirituality/counselling and social media to ensure the needs of younger residents are met.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. Windsor Park has a four-weekly roster in place which ensures there are adequate staffing levels to meet the acuity and safety needs of the residents. The care home manager and clinical manager are available during weekdays. The care home manager and the clinical manager share the on-call duties. Adequate RN cover is provided 24 hours a day, seven days a week. There is one RN on duty on the morning, afternoon and night shifts in the hospital and provides support across the rest home and dementia unit. The CM also provides support and oversight to the rest home and dementia unit.</p> <p>In the hospital (20 hospital including three YPD), there are four caregivers on duty in the morning, afternoon shifts and one caregiver on the night shift. In the rest home (26 rest home residents) there are two caregivers on duty in the morning and afternoon shifts, and one caregiver on the night shift.</p> <p>In the dementia care unit (16 dementia residents) there are two caregivers on duty in the morning and afternoon shifts, and one caregiver on the night shift. Interviews with residents and family members identified 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>	FA	<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, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is a comprehensive admission policy. Residents are assessed prior to entry to the service by the needs assessment team. Specific information is available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service and residents and/or family/whānau are provided with associated information such as the Code, how to access advocacy and the health practitioners code. There is also specific information for relatives in relation to the dementia unit. All relatives interviewed were familiar with the contents of the pack.</p> <p>The care home manager and clinical manager screen admissions prior to entry to ensure a needs</p>

		assessment has been completed and the service is able to provide the level of care required, if there is a room available.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record is kept and a copy of which is kept on the resident's file. All relevant information is documented on the Bupa transfer form and accompanied with a copy of the resident admission form, most recent GP consultation notes and medication information. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification of appointments and transfers. Relatives interviewed confirmed that they are notified and kept informed of the resident's condition. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place which comply with current legislation. Medicines are stored in accordance with legislation and current guidelines. Medications are pre-packed in blister packs and stored in a locked trolley in the treatment room in each wing. Medicine administration practice complied with the medicine management policy in the medicine round observed. Medications are administered by registered nurses in the hospital wing, and medicine competent care staff in the rest home and dementia wings. Staff that administer medications complete a medicine competency and medication management annually. Registered nurses undertake extra training to administer syringe drivers and subcutaneous fluids. Medications are prescribed on the electronic medicine management system in accordance with legislative prescribing requirements for all regular and 'as required' medicines. Medications are checked on admission and on arrival to the facility and discrepancies are reported to the pharmacy.</p> <p>The service does not have standing orders and verbal orders are rarely used as an electronic system is in place. There was no expired stock on-site on day of audit. Medication fridge temperatures are checked at least weekly and temperatures are within acceptable ranges. Oxygen and suction is checked weekly (checklist sighted). The GPs review the medication charts at least three-monthly. A review of 16 medication signing sheets evidenced that administration of all medications aligned with the medication charts.</p> <p>One resident was self-medicating on the day of audit. The GP evaluates the resident's competence on a three-monthly basis. Medicines are kept in a locked drawer in the resident's room. Staff check with the resident each day whether medications have been taken.</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>CI</p>	<p>All meals are prepared and cooked on-site. A Bupa-wide summer and winter menu are of a six-weekly cycle. There is a monthly on-line forum for all Bupa facilities cooks. There are three kitchen staff on duty each day including a qualified cook (8am-4.30pm) and morning and afternoon kitchenhands. The national menus have been audited and approved by an external dietitian. Meals are served from the bain marie in the kitchen to residents in the rest home dining room and transported in hot boxes to bain maries, to the hospital and dementia unit kitchenettes, and served by care staff. The cook serves the meals in the hospital wing at lunchtime to monitor 'who is eating and who is not'. The cook attends the twice weekly clinical meetings and keeps abreast of changes in resident weight status. All kitchen staff (two cooks and four kitchenhands) have NZQA167 qualifications. Both cooks have NZQA168 qualifications.</p> <p>Resident likes and dislikes are known and alternative choices offered. The residents have a nutritional profile developed on admission and the kitchen staff receive a copy, which identifies the residents' dietary requirements and likes and dislikes. Special diets include gluten free, no pork and moulded. Lip plates and specialised utensils are provided to promote and maintain independence with meals. Staff were observed in the hospital wing assisting residents with their meals at the midday meal.</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>There is an admission information policy. The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry to potential residents and communicates this to potential residents/family/whānau. Potential residents would be referred back to the referring agency if entry is declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Windsor Park Care Home uses the Bupa assessment booklets and person-centred templates for all residents. The assessment booklet includes including; falls, Braden pressure area, skin, mini nutritional, continence, pain (verbalising and non-verbalising), dependency and activities and culture. Nutritional requirements are completed on admission. Additional risk assessment tools include behaviour and wound assessments as applicable. The outcomes of risk assessments are reflected in the care plan.</p> <p>InterRAI assessments had been completed within timeframes and areas triggered were addressed in care plans sampled. The respite file had comprehensive short stay assessments completed. Behaviour assessments are completed as required.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>In all eight files sampled, the assessments completed on admission had been used to plan care for the resident. Care plans sampled were comprehensive, showed attention to detail, and were integrated with other allied health services involved in resident care. Relatives and residents interviewed all felt they were involved in the planning of resident care. In all eight files sampled, there is evidence of resident and relative involvement in care planning.</p> <p>Care plans reviewed provided evidence of individualised support. Short-term care plans are in use for short-term needs and changes in health status.</p> <p>The one YPD file reviewed was resident-centred, including interventions to support ADLs and medical needs. The care plan also identified specific goals around activities and community involvement. Resident-centred goals were reviewed at the multi-disciplinary review (MDR) meetings with the residents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The registered nurses complete care plans for residents. Progress notes in all eight files sampled had detailed progress which reflected the interventions detailed in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. There is evidence of wound nurse specialist involvement in chronic wounds/pressure areas. In the rest home and hospital areas, there were three chronic ulcers (two diabetic and one venous) two skin tears, two abrasions, and one superficial scab. There were no wounds in the dementia unit at time of audit. All wounds have wound assessments, plans and ongoing evaluations completed.</p> <p>The registered nurse attends to the wound dressings, an assessment and evaluation is completed at each dressing change. The enrolled nurse attends to wound dressings in the rest home wing under the supervision of the registered nurse. The registered nurse countersigns all assessments and evaluations completed by the enrolled nurse. Photographs are taken to reflect improvement or deterioration. All chronic wounds are documented in the long-term care plans with interventions for care staff around the dressing changes, signs and symptoms of infection, position changes and the like.</p> <p>Sufficient continence and dressing supplies are available.</p> <p>Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two hourly turning charts, and behaviour monitoring charts.</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>	<p>FA</p>	<p>There is one fully qualified diversional therapist. The diversional therapist is involved in the admission process completing the initial activities assessment and has input with the cultural assessment, 'map of life' and 'my day my way' adding additional information as appropriate. The diversional therapist works full-time and is responsible for activities across the rest home, hospital and dementia unit. The activities programme has input from a Bupa occupational therapist, and Bupa dementia care advisor to ensure the needs of the residents are met. The diversional therapist has first aid certificates. An activities plan is completed within timeframes, a monthly record of attendance to activities is maintained and evaluations are completed six-monthly. A monthly activities programme is given to all residents, and is displayed on noticeboards throughout the facility. There are general activities for all residents to join in and activities for more able residents.</p> <p>The diversional therapist stated the programme may vary according to resident requests such as playing different games or outings delayed due to weather, or extra outings if weather is nice in the summer time. Activities are from 9am through to 5pm on weekdays with staff oversight of weekend activities in the dementia unit. A separate activities plan is developed for the dementia unit and covers 24 hours. During the summer months, there are extra van rides arranged for later in the afternoon when residents can become unsettled.</p> <p>Activities for younger people include van rides when weather is nice, walks in wheelchairs. The diversional therapist takes time to get to know these residents and what their hobbies and interests have been prior to admission. Staff are aware to ensure these residents are at the front if there are entertainers. There is a range of music available to listen to right up through the ages. Trips in the community have included (but not limited to) visits to other facilities for competitions, and games, trip to the country music festival and the local A & P show. There are three-monthly resident meetings, where residents have the opportunity to provide feedback on all aspects of the facility</p> <p>Residents interviewed stated they feel the activities are very good, and they are kept as busy as they want to be.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans are reviewed and evaluated by the registered nurse at least six-monthly or more frequently to reflect changes in health status, in six of eight files sampled. One respite resident had been in the facility for a week. One dementia level resident had been in the facility for less than six months. Six monthly multi-disciplinary reviews (MDR) and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person involved in the care of the resident. Family members are invited to attend the MDT review. The review checklist identifies the family member who has attended the review. There is at least a one three-monthly review by the medical practitioner. There are short-term care plans available to focus on acute and short-term issues. These are evaluated at regular evaluations. Wound care charts were evaluated in a</p>

		timely manner. Care plans are updated when needs change.
<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>Referrals to other health and disability services were evident in the sample group of residents' files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. Examples of referrals sighted were to occupational therapist, physiotherapy, dietitian, mental health services, speech language therapist, and RN community mental health nurse, and hospital specialists. Discussions with the clinical manager and two registered nurses identified that the service has access to GPs, ambulance/emergency services, allied health, dietitians, physiotherapy, continence and wound specialists, and social workers.</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 is a chemical/substance safety policy. There are policies on the following: waste disposal policies for medical, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. Management of waste and hazardous substances is covered during orientation of new staff. Staff attended chemical safety education in April 2017. Chemicals are stored in a locked cupboard. Safety datasheets and product wall charts are available. Approved sharps containers are available and meet the hazardous substances regulations for containers. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff are observed wearing appropriate personal protective clothing when carrying out their duties. Cleaning staff take cleaning trolleys into the resident rooms or they are in their line of sight so that chemicals are not left unattended.</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 building holds a current building warrant of fitness, which expires on 6 August 2018. Reactive and preventative maintenance occurs. There is a full-time maintenance person on staff. There is a 52-week planned maintenance programme in place. The checking of medical equipment including hoists, has been completed on 2 August 2017. The hot water temperatures are monitored weekly on a room rotation basis. Temperatures were recorded between 39 – 45 degrees Celsius. The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen areas. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required.</p> <p>There is outdoor furniture and seating with shade sails in place and there is wheelchair access to all areas. There is a designated resident smoking area for the rest home and hospital area. There is keypad entry to the secure unit. The outside area in the dementia unit is secure with a padlock on an</p>

		external gate and gardens are well maintained with easy access from lounge areas. There are a number of external doors from the secure unit that open into the secure outside area. The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including tilting shower chairs, shower trolleys, commodes, sliding sheets, electric beds, ultra-low beds, sling and standing hoists (eight hoists in total), nine pressure mattresses, wheel-on scales wheelchairs, sensor mats, landing mats, mobility aids, continence supplies, dressing and medical supplies. Registered nurses stated that when something that is needed is not available, management provide this in a timely manner.
<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	All bedrooms have hand basins. The rest home wings (Waimea and Croydon) have bedrooms with ensuites. There are two hospital rooms with a shared ensuite and two rooms with their own ensuites. There are adequate numbers of communal toilets and shower rooms located near the bedrooms without ensuite facilities. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Slide signs indicate whether the communal toilet/showers are vacant or in use. Residents interviewed reported their privacy is maintained at all times.
<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	All bedrooms are single. The hospital bedrooms are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Staff interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms have wide doors for bed evacuation or ambulance trolley access. Residents are encouraged to bring their own pictures, photos and small pieces of furniture to personalise their room.
<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	There are spacious open plan lounges and dining rooms in the rest home, hospital and dementia wings. The service has a family room with tea/coffee making facilities. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Residents can move around freely and furniture is well-arranged to facilitate this. The hospital dining room and lounges accommodate specialised lounge chairs. Seating and space is arranged to allow both individual and group activities to occur. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.

<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>There are policies in place including cleaning department, use of equipment policy and cleaning schedules. There is also a cleaning schedule/methods policy for cleaners. All laundry and personal clothing is laundered on-site. There is a dedicated laundry person from 7.00am – 3.00pm daily. There is a defined clean/dirty area within the laundry which also has an entry and exit door. There is a designated washing machine and dryer in the event of an outbreak. Cleaning and laundry staff were very knowledgeable around outbreak management. Chemicals are stored securely in the laundry area. The chemical product supplier conducts regular quality control checks on the effectiveness of chemicals used and the washing machine cycles.</p> <p>A sluice area and sanitiser is located within the dirty area of the laundry room. There is a dedicated cleaner for each of the services, six hours per day Monday to Sunday. Cleaning products are colour coded, for example mop heads for each area. Personal protective equipment is available in the laundry, cleaning and sluice room. Staff were observed to be wearing appropriate protective wear when carrying out their duties.</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. Fire evacuation drills take place every six months, with the last fire drill occurring on 4 July 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 backup system for emergency lighting and battery backup. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available.</p> <p>There are civil defence kits in the facility that are checked 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 visitor's 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</p>	<p>FA</p>	<p>The facility has underfloor heating and ceiling panels throughout the personal and communal areas. Bedrooms have additional heating provided (oil filled heaters) for individual residents as required. All communal rooms and bedrooms are well ventilated and well lit. Residents and family members interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in residents' rooms.</p>

that is maintained at a safe and 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, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The infection control coordinator is a registered nurse. There is a job description for the infection control coordinator with clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The committee and the governing body are responsible for the development of the infection control programme and its review. The programme was last reviewed in June 2016. There are quarterly infection control meetings that combine with the health and safety meetings. The quality meetings also include a discussion and reporting of infection control matters, trends and quality improvements.</p> <p>Information from these meetings is communicated to the registered nurse and staff meetings. The service has experienced one separate norovirus outbreak in May 2017, which included residents and staff that were managed. Public Health were notified within four days of first signs of outbreak. Regular contact and updates were maintained with Public Health South. Accident forms were completed for each resident and staff member affected. Short-term care plans were in place for affected residents which reflected isolation for 48 hours after last episode of symptoms. Staff all stayed off work in accordance with infection policy. Norovirus outbreak meetings were held daily from 15 May until 19 May (last person to become sick) with a good log of responsibilities for staff – cleaners, laundry, kitchen, maintenance. The kitchen supplied meals using disposable crockery and cutlery.</p> <p>The laundry had a designated washing machine and dryer. Cleaning staff were to ensure a good supply of hand gels, soap and paper towels were available. Maintenance was to ensure a good supply of PPE, continence product was readily available, and outbreak kit was kept fully stocked. A special infection control report was completed 15 May 2017. A corrective action plan was commenced on 15 May and signed off on 2 June. Outbreak policy was filed along with outbreak documentation. Sample of posters displayed to alert relatives and visitors was filed. Norovirus was stated for specific testing on laboratory forms. Staff training and debrief was held in June 2017. Staff are vigilant of future outbreaks. Cleaning, laundry, kitchen, registered nurses and care givers are very aware of outbreak procedures and can describe these easily.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human,</p>	FA	<p>The infection control programme is discussed at the quality meetings. Members include heads of departments such as kitchen, cleaning, laundry, activities, care staff, infection control coordinator, clinical manager and home care manager. The facility also has access to an infection control nurse at</p>

<p>physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>the district health board (DHB), public health, GPs, laboratory and expertise within the organisation.</p> <p>The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or have been in contact with infectious diseases. Alcohol based hand gel is available throughout the facility.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff.</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 coordinator is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control questionnaires and hand hygiene checklist. If there is a noted increase in infection rates, there is education sessions held around this. An education session around outbreak management was held by Southern DHB infection control nurse in June 2017.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) and clinical manager use the information obtained through surveillance to determine infection control activities, trends, resources, and education needs within the facility.</p> <p>Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator with corrective action plan. There are standard definitions of infections in place appropriate to the complexity of service provided.</p>

		<p>Infection control data is collated monthly and reported at the quality, and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The clinical manager and infection control coordinator meet monthly and keep track of infections in each unit. The infection control programme is linked with the quality management programme. The results are subsequently included in the care home manager's report on quality indicators.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 staff confirmed their understanding of restraints and enablers. At the time of the audit, the service had four residents using restraints (four lap belts) and one resident with a lap belt as an enabler. Staff training around restraint minimisation and management of challenging behaviours was last completed in June 2017.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (registered nurse) and for staff are documented and understood. 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>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Ongoing consultation with the resident and family/whānau was evident. The files for three residents using restraint and one resident using an enabler were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). Falls risk assessments are completed six-monthly and interRAI assessment identifies risk and the need for restraint.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The approval process includes ensuring the environment is appropriate and safe. Files reviewed demonstrated that assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The care plans reviewed also identified observations and monitoring. Restraint use is reviewed through the three-monthly assessment evaluation, monthly restraint meetings and six-monthly multidisciplinary meeting which includes family/whānau input. A restraint register is in place providing a record of restraint use and is completed for residents requiring restraints and enablers.</p>
<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). Evaluation has occurred three-monthly as part of the ongoing reassessment for the residents on the restraint register and as part of their care plan review. Evaluation timeframes are determined by risk levels. Files sampled demonstrated that appropriate evaluations are occurring.</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>Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the regional restraint approval group teleconference meeting and information is disseminated throughout the organisation.</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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six-monthly or annually as designated by the internal auditing programme schedule. Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee (e.g., quality, staff), and an action plan is identified. Benchmarking reports are generated throughout the year to review performance over a 12-month period.</p> <p>Quality action forms are utilised at Windsor Park and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are</p>	<p>Reducing falls was one of the facilities quality and health & safety goals for 2017to reduce by 20% from 2016. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>Strategies included (but not limited to) alert stickers placed on the doors of residents who are high falls risk, resident exercise classes run two times a week to help keep residents’ mobile and improve strength and stability, decluttering of resident rooms and that call bells are within reach, continued falls prevention education for all staff and falls data analysis discussed weekly and available for all staff to view. Documentation reviewed identified that strategies were regularly evaluated. The outcome achieved was that the total of resident falls for the period from 1 July 2015 to 30 June 2016 was at 122, the total of falls reduced by 15% for the period 1 July 2016 to 30 June 2017 to 104 falls.</p>

		identified. There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Windsor Park is proactive in developing and implementing quality initiatives. All meetings include excellent feedback on quality data where opportunities for improvement are identified.	
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	CI	<p>The food service is constantly being reviewed to determine resident satisfaction and whether more food is being wasted by not being eaten for specific meals or by specific groups of residents. There re snacks available between meals in the dementia unit. Residents interviewed all spoke positively about the food and choices provided.</p>	<p>Following a satisfaction survey in 2016, the facility chose to look at food services as an improvement.</p> <p>Whiteboards have been purchased displaying resident likes, dislikes, preferences and allergies as a quick reference to those serving meals. Bain maries were tested, and plates are now warmed up before meals to ensure the meals are served hot. The cook regularly asks residents about the meals, their likes and dislikes, suggestions, and tries to accommodate their requests. The dementia and hospital units receive extra desserts with the evening meal as the cook noted the waste coming was mainly from the main meal at lunchtime.</p> <p>The dessert can be offered for supper as an extra snack or at the tea time meal as an alternative. Bupa has introduced moulds for moulied diets so the plate looks more attractive, which has been trialled and staff are awaiting training around this.</p> <p>The satisfaction survey in 2016 showed 17% excellence for meals and 26% in 2017.</p>

End of the report.