

# Bupa Care Services NZ Limited - Cedar Manor Rest Home & Hospital

---

## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Bupa Care Services NZ Limited
<b>Premises audited:</b>	Cedar Manor Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 14 November 2017    End date: 15 November 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	83

# 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

Cedar Manor is part of the Bupa group. The service is certified to provide rest home, hospital (medical and geriatric), and dementia level care for up to 92 residents. On the day of the audit, there were 83 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 fourteen months. She is supported by an experienced clinical manager.

There are quality systems and processes being implemented that are structured to provide appropriate quality care. Implementation is supported through the Bupa quality and risk management programme that is individualised to Cedar Manor. 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 quality and good practice.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
--	--	---

Cedar Manor 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.		Standards applicable to this service fully attained.
---	--	--

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. A risk management programme is in place, which includes managing adverse events and health and safety processes.

Cedar Manor is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. 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, demonstrate a culture of quality improvements.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place. 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.		Standards applicable to this service fully attained.
--	--	--

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

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.
--	--	--

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 staff member trained in first aid 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.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents on restraint and two residents with enablers. Assessments and consents were completed for the 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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	44	0	0	0	0	0
<b>Criteria</b>	2	91	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. 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 (last completed February 2017). Interviews with staff (six caregivers [across all areas], three registered nurses, care home manager, clinical manager, and three 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</p>	FA	<p>The service has a policy in place for informed consent and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents and signed outing consents on 10 of 10 resident files sampled (four rest home, four hospitals, two dementia care). Resuscitation treatment plans, and advance directives are appropriately signed in the 10 files reviewed.</p> <p>Discussions with caregivers confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. Discussions with registered nurses identified that staff are familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive.</p>

consent.		Ten resident files reviewed had a signed admission agreement.
<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	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>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	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 at least two monthly and relatives are invited to attend events and MDT meetings. Monthly newsletters are provided to residents and relatives.
<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. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. Twelve complaints received in 2017 (YTD) were reviewed with evidence of appropriate follow-up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints. Feedback is provided to staff and toolbox talks were completed where required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All 11 residents (seven rest home level and four hospital level) and four relatives (one rest home, one hospital, two dementia)</p>

		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	Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. The 2017 satisfaction survey identified 89% of residents were happy with privacy. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training (last completed August 2017). Residents admitted to the dementia unit (Bakker unit) are assisted and supported to maintain as much independence as possible.
<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. There are two residents whom identify as Māori living at the facility. A file review identified involvements in specific Māori community events as requested by the resident.</p> <p>Māori consultation is available through the documented iwi links and local Māori ministers. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. The 2017 satisfaction survey identified 62% outcome for cultural/spiritual needs being met which is an improvement on 2016 survey. Monthly newsletters are provided to residents and relatives.</p> <p>All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>
Standard 1.1.7: Discrimination	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Code of conduct training is also provided through the in-service training programme.

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>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 Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<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 GP visits the facility two days a week as needed. A number of residents have retained their own GPs. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on-site, 10 hours per week with the support of a physiotherapy assistant. There is a regular in-service education and training programme for staff. Several questionnaires have been introduced for staff that miss training sessions. In-service education includes sessions across 3x day to meet the needs of all staff on rostered shifts. 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. Cedar Manor is benchmarked against the rest home, hospital and dementia data. If the results are above the benchmark, a corrective action plan is routinely developed by the service.</p> <p>Cedar Manor has been proactive around implementing quality initiatives (Quality action forms). These are established for areas that staff/management identifies as requiring improvement and these are evaluated for effectiveness.</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.</p> <p>Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Twenty-four accident/incident forms reviewed across the three service areas (from August 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</p>

		<p>indicated. The information pack is available in large print and is read to residents who require assistance.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Cedar Manor Rest Home and Hospital is a Bupa residential care facility. The service currently provides care for up to 92 residents at hospital (geriatric and medical), dementia and rest home level care. On the day of the audit there were 83 residents including; (i) 23 hospital residents and 11 rest home residents in the 38-bed hospital wing – Central unit; (ii) 28 rest home residents and 7 hospital residents in the 36-bed rest home wing – Craig unit; and (iii) 14 residents in the 18-bed secure dementia unit – Bakker unit. There were not residents under the medical component of their certification. All residents were on an ARCC contract. There are 25 dual-purpose beds across the rest home and hospital units.</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.</p> <p>Cedar Manor is part of the midlands1 Bupa region and the managers from this region teleconference weekly and meet six monthly to review and discuss the organisational goals and their progress towards these. The care home manager provides a weekly report to the Bupa operations manager. The operations manager teleconferences monthly and completes a report to the director of care homes and rehabilitation.</p> <p>A quarterly report is prepared by the care home manager and provided to the Bupa clinical service improvement team on the progress and actions that have been taken to achieve the Cedar Manor quality goals.</p> <p>Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia, (eg, mortality and pressure incidence rates and staff accident and injury rates). Benchmarking of some key indicators with another NZ provider is also in place.</p> <p>Cedar Manor is implementing three goals in 2017 (two national goals and one facility specific). Progress to meeting these goals is reviewed at every meeting and a progress report documented quarterly.</p> <p>The care home manager has a background in hospitality and has been in the role since August 2016. She has been with Bupa since 2009 and has managed a number of Bupa facilities. An experienced clinical manager has been in the role for the last three years. The management team is supported by two unit-coordinators.</p> <p>The care home manager and clinical manager have maintained over eight hours annually of professional</p>

		development activities related to managing an aged care service.
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>A clinical manager/registered nurse (RN) who is employed full time, supports the care home manager, and steps in when the care home manager is absent. The operations manager, who visits regularly, supports both managers.</p> <p>The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and promotes quality of life.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A quality and risk management programme is well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed.</p> <p>Riskman has recently been implemented by Bupa which is an electronic data collecting system. All incidents, complaints, infections, pressure injuries, falls, category one incidents are completed on the online system. Reports are automated and further analysis is completed of those reports. Cedar Manor reports, analysis and consequent corrective actions were sighted.</p> <p>Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements.</p> <p>Quality and risk data is shared with staff via meetings and posting results in the staff room.</p> <p>An annual satisfaction survey is completed, and 2017 results demonstrated an 88% positive outcome. Corrective actions were established in areas identified as below the national average.</p>

		<p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There is an appointed health and safety officer who is supported by health and safety representatives. The health and safety team meet's monthly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. The hazard register is reviewed regularly. Bupa belongs to the ACC partnership programme and has attained their tertiary level (expiry 31 March 2018).</p> <p>Strategies are implemented to reduce the number of falls. This includes, (but is not limited to), a falls focus group has been established to review all falls, ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding. Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Caregiver interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>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. The organisation has recently implemented the Riskman electronic monitoring system. All incidents are coded in severity on Riskman (severity 1-4) with 4 being the most severe. All resident incidents logged with a severity of 3 or 4 are automatically escalated to the Bupa CSI (clinical services improvement) team immediately and the operations manager. Actions are then followed-up and managed.</p> <p>Twenty-four accident/incident forms were reviewed across the three service areas (from August 2017). Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Incidents are benchmarked and analysed for trends (link 1.2.3.6).</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. One gastric outbreak was notified to public health and DHB May 2017.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and</p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Ten staff files (unit coordinator, three RNs, cook, activity coordinator, four caregivers) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg,</p>

<p>meet the requirements of legislation.</p>		<p>RN, support staff) and includes documented competencies. New staff are buddied for a period of time (eg, caregivers two weeks, RN four weeks), and during this period they do not carry a clinical load. The caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. Currently 100% of the caregivers have level two. From this, they are then able to continue with Core Competencies Level 3, unit standards. These align with Bupa policy and procedures. There are nine caregivers that work in the dementia unit that have completed the dementia standards, four are in process of completed and two are new staff.</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 district health board and through Bupa clinical training forums.</p> <p>Bupa is the first aged care provider to have a council approved PDRP. Bupa takes over the responsibility for auditing their qualified nurses. At Cedar Manor, one RN has completed PDRP; three RNs are currently working on their portfolio on the Bupa Nursing Council approved PDRP. Of the 10 RNs at Cedar Manor, eight RNs have completed interRAI training and two are to commence next week.</p> <p>Since the previous audit the service implemented a quality goal to improve the uptake of education by 65% annually, which they have achieved by implementing some of the following strategies; (i) registered nurses are now involved in presenting education monthly; (ii) education sessions are now being presented three times for each topic to allow all staff to choose the time they can attend. Education held at 11:00, 14:00 and 22:00 hours. (iii) Crosswords and word finder being used as well as questionnaires for the staff who cannot attend due to family or personal commitments</p> <p>A competency programme is in place with different requirements according to work type (eg, support work, registered nurse, and cleaner). Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files).</p> <p>RN competencies include assessment tools, BSLs/insulin admin, CD administration, moving &amp; handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, CPR and T34 syringe driver.</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</p>	<p>FA</p>	<p>The staffing levels meet contractual requirements. The clinical manager is on-call after hours with other registered nurses. The care home manager and clinical manager are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers' support RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p> <p>Bakker unit (14 residents in a secure dementia unit)</p>



<p>providers.</p>		<p>AM shift – unit coordinator (RN) Monday-Friday and senior caregiver Saturday/Sunday. Two caregivers (one long shift, one short shift)</p> <p>PM shift – one senior caregiver lead, two caregivers (one long shift, one short shift)</p> <p>Night shift - one clinical lead (RN - across dementia and rest home) and one caregiver.</p> <p>Activity person– Monday-Friday 09:45 – 15:15</p> <p>Hospital residents (across Central and Craig units – 30 residents)</p> <p>AM shift – unit coordinator or clinical lead (RN) Monday- Sunday. Five caregivers (three long shifts, two short shift)</p> <p>PM shift – one clinical lead (RN), four caregivers (two long shifts, two short shift)</p> <p>Night shift - one clinical lead (RN), two caregivers</p> <p>Activity person – Monday-Friday 09:30- 15:30</p> <p>Physiotherapy assistant – Monday-Friday 0900 - 1300</p> <p>Rest home residents (across Central and Craig units – 39 residents)</p> <p>AM shift –clinical lead (RN) Monday-Sunday; three caregivers (two long shifts, one short shift)</p> <p>PM shift – one clinical lead (RN), three caregivers (one long shift, two short shift)</p> <p>Night shift - one clinical lead (RN) shared with dementia (RN), one caregiver</p> <p>Activity person – Monday-Friday 08:30- 16:30</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>Residents’ files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation.</p>

<p><b>Standard 1.3.1: Entry To Services</b></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>	<p>FA</p>	<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. The unit coordinator and registered nurse's interviewed stated that there is good liaison and communication with the needs assessors, social worker, mental health team, GPs and nurse practitioner.</p> <p>The care home manager and clinical manager screen admissions prior to entry to ensure a needs assessment has been completed and the service is able to provide the level of care required, if there is a room available.</p>
<p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to podiatry, dietitian, mental health services and wound care specialists.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<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. The GPs review the medication charts at least three-monthly. A review of 20 medication signing sheets evidenced that administration of all medications aligned with the medication charts.</p>

		There were eight rest home resident's 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>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals are prepared and cooked on-site. 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 temperature of the food is checked before leaving the kitchen and again before being served. There is a chef on duty daily and he is supported by a morning and evening kitchenhand. Bupa-wide summer and winter menus have been audited and approved by an external dietitian. The cook is notified of all changes in resident's dietary requirements. All kitchen staff (one kitchen manager, two part-time cooks and five kitchenhands) have attended relevant training. The kitchen manager is a trained chef with over five years' experience in providing meals for aged care.</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, high protein, soft, and moulied. 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>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 are snacks available between meals in the dementia unit. Residents interviewed all spoke positively about the food and choices provided. Following a satisfaction survey in 2016, the facility chose to look at food services as an improvement.</p> <p>The current operation was assessed, and shortfalls identified constraints in time and staff resources. Following discussions with the residents, decisions were made to trial a new meal service changing the main meal of the day to 5pm. This involved changing staff hours and increasing kitchenhand hours. These changes allowed the service to improve meal quality, condiment availability. The satisfaction survey in 2016 showed 17% excellence for meals and 26% in 2017.</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</p>	FA	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 to the referring agency if entry is declined.

<p>consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Cedar Manor uses the Bupa assessment booklets and person-centred templates for all residents. The assessment booklet includes; 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. Challenging behaviour assessments were completed when needed.</p> <p>InterRAI assessments had been completed within timeframes and areas triggered were addressed in care plans sampled.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>In all ten 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 ten 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>Resident-centred goals were reviewed at the multi-disciplinary review (MDR) meetings with the residents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions 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 ten 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, there were seven wounds (involving six residents) including one grade two pressure injury, two ulcers, two skin lesions and two skin tears. In the hospital areas, there were four pressure injuries (involving two residents), five skin tears, and one skin lesion. There were two wounds (one skin tear and one ulcer) 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</p>

		<p>dressing change. 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>Dressing supplies are available and sighted in the hospital treatment room and dressing trolleys are well stocked in each unit. Continence products are available and sighted, and it is recorded in the care plan which product is needed and when.</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><b>Standard 1.3.7: Planned Activities</b></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 qualified activities coordinator working full time 5 days per week and two activities assistants working part time five to six hours per day and three hours on alternating Sundays. All activities staff are involved in the admission process completing the initial activities assessment and have input with the cultural assessment, 'map of life' and 'my day my way' adding additional information as appropriate. The activities coordinator works full-time and is based in the rest home but is responsible for coordinating activities across the rest home, hospital and dementia unit. An activities assistant is based in each of the hospital units 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. All activities staff have current 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>Activities are from 9am through to 5pm six days per week with staff oversight of Sunday activities in the dementia unit. Residents are involved in leading some of the activities including bingo, art &amp; craft, bowls, shop trolley, rummicub, sunshine club, knitting clubs and quiz sessions. The activities staff have one-on-one time with residents who are unable or who choose not to participate in the programme. There are van outings at least three times a week. There is a separate programme for the residents in the dementia unit. There may be group or individual activities, and these focuses particularly on cognitive, sensory and physical activities such as music, reminiscing, exercise, poetry and hand massage. There are memorabilia available to residents. On the week of audit, the facility was celebrating race day and many residents were actively engaged.</p> <p>Trips in the community have included (but not limited to) visits to other facilities for competitions, and games, a trip to the local marae and the Mount. Bupa Cedar Manor have recently revitalised their programmes and improved resident satisfaction. There are regular resident meetings, where residents</p>

		<p>have the opportunity to provide feedback on all aspects of the facility.</p> <p>Residents interviewed acknowledged the recent improvement and 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>	FA	<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 four of ten files sampled. Six residents (four rest home, one hospital and one dementia level) had been in the facility for less than six months.</p> <p>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 MD 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 timely manner. Care plans were updated when needs change.</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>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,</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 March 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 were observed wearing appropriate personal protective clothing when carrying out their duties.</p>

infectious or hazardous substances, generated during service delivery.		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>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 16 February 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 in August 2017. The hot water temperatures are monitored weekly on a room rotation basis. Temperatures were recorded between 39 – 45 degrees Celsius. The corridors are wide in the Craig wing and adequate in all other areas to promote safe mobility with the use of mobility aids and transferring equipment. There are handrails in all corridors which promotes safe mobility. Residents were observed moving freely around the areas with mobility aids, where required.</p> <p>The external areas and gardens are well maintained and easily accessible (including wheelchairs). There is a balcony surrounding the entrance where residents can be seated in shaded areas and additional outdoor furniture throughout the garden 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 and gardens are well maintained with easy access from lounge areas. 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, 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> <p>The service has made a number of improvements to the environment since previous audit. New dining room tables and chairs were purchased for the rest home. Bakker unit also received new tables and chairs. Lounge chairs purchased for rest home, Bakker lounges painted, bedrooms were being painted as they are vacated.</p> <p>Craig wing hallways are currently being upgraded, patched wallpaper removed, wall boards have been attached to lower level and painting of wallboards in progress.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are</p>	FA	<p>All bedrooms in the Craig wing (dual-purpose) have ensuite showers and toilets. In the Central wing, which caters for dual-purpose residents and Bakker wing for dementia level of care, there are adequate numbers of communal toilets and shower rooms to meet resident needs. A visitors' toilet is situated just off the main entrance between Central and Craig wings. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Shower rooms have privacy curtains. The residents interviewed</p>

<p>assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>reported that their privacy is maintained at all times.</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>	<p>FA</p>	<p>All bedrooms in Craig wing are single and spacious. In the Central wing, the rooms are single but there are two larger rooms which can be shared by husband and wife. In the Bakker wing which caters for dementia residents, the rooms are small singles, but they are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Residents are encouraged to personalise their rooms as sighted.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are spacious lounges in each area and there are also smaller lounges where residents can sit alone or in small groups. Each area (Craig, Central and Bakker) has a separate dining room. Food is served from bain maries which come from the main kitchen. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Residents are able to move freely, and furniture is arranged to facilitate this. The dining rooms and large lounges accommodate lounge chairs. There is adequate seating and space to allow for individual and group activities to occur. There are tea/coffee making facilities for families and residents. The dementia unit has two external doors opening from the main dining area allowing safe secure access to the gardens. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>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. The laundry is located downstairs in a utility area. The area has a gate with a latch on the laundry side preventing residents from accessing the stairs. This prevents residents from unauthorised access. The gate is clearly labelled for staff access only. There is a dedicated laundry person. A recent change in laundry staffing hours to 8.30am – 3.00pm with another shift introduced from 4.30pm – 8.30 has had a positive impact on the service. There is a defined clean/dirty area within the laundry with a laundry chute delivering soiled linen at one end and a laundry lift to take the clean laundry back up. Cleaning and laundry staff were very knowledgeable around outbreak management. Chemicals are stored securely in a locked storage room adjacent to the laundry. The chemical product supplier conducts regular quality control checks on the effectiveness of chemicals used and the washing machine cycles.</p> <p>A sanitiser is located in dedicated sluice rooms. Personal protective equipment is available in the cleaner's cupboards and in the sluice rooms. The cleaning trolleys are locked in the cleaner's cupboards when not in</p>



		<p>use. All cleaning chemicals are clearly labelled. Safety data sheets are in the cleaner's cupboards and the laundry. Cleaners are observed to be wearing appropriate protective wear when carrying out their duties.</p> <p>Laundry and cleaning staff have attended chemical safety training. Laundry and cleaning internal audits have been completed.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>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. The maintenance person is the fire safety officer. 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. The dementia unit has a secure 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>	FA	<p>All communal rooms and bedrooms are well ventilated and light. The facility has heat pumps and gas heating. The temperature of the facility is comfortable. All bedrooms have external windows which let in natural light.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises</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. Staff are well informed about infection control practises and reporting. The infection control coordinator is a registered nurse and she is responsible for infection control across the facility. The committee and the Bupa governing body in conjunction with Bug Control, is responsible for the development of the infection control programme and its review. The infection control</p>

<p>the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>programme is well established at Cedar Manor. The infection control committee consists of a cross-section of staff and there is external input as required from general practitioners, Bupa quality &amp; risk team as needed. There has been one gastric outbreak since the previous audit (21 May 2017) which involved 16 residents across the facility. Daily update meeting minutes and management meeting minutes were completed. A case log was maintained, and Public Health notified. Outbreak management team debrief/quality review meeting minutes (dated 31 May 2017) identified the outbreak was well managed.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Cedar Manor. The infection control (IC) nurse is new to the role and has completed/maintained best practice by attending infection control updates through Bug control. The infection control team is representative of the facility. External resources and support are available through the Bupa clinical services team when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. The infection programme policy is currently being updated to include the surveillance process around Riskman.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held, including (but not limited to) infection prevention (February, May and June</p>

<p>relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>2017), handwashing (February 2017), and outbreak management (May 2017).</p> <p>The infection control coordinator has received education both in-house and by an external provider to enhance her skills and knowledge. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice and group benchmarking.</p> <p>A number of toolbox talks have been provided including (but not limited to) preventing UTIs, flu/cold prevention, and soiled linen procedures.</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>The infection programme policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service has recently implemented the Riskman electronic reporting system (end of August). Infections are now logged in Riskman as an 'event' for each resident affected. These infections must meet the IFC criteria to be logged. Each infection is coded with a severity rating (1-4). Reports are run off Riskman for further analysis and trends.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and southern community laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the</p>

		<p>facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff.</p> <p>Infections statistics are included for benchmarking. Quality indicator - corrective action plans (QI-CAPs) are established where trends are identified. Examples (but not limited to): rest home completed a CAP in August for increase in UTIs, the hospital completed a CAP in September for increase in chest infections and the dementia unit completed a CAP in October for increase in UTIs.</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. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and regional restraint meetings and at an organisational level. Interviews with the staff confirm their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service was restraint-free. There were two residents with enabler including bedrail and safety belts. All enabler use is voluntary. One resident file of enabler use was reviewed. The enabler assessment form was completed and signed by the resident. The care plan identified the enabler use and risks were documented. These had been evaluated at least three monthly.</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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>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. Several core clinical practices also have education packages/competencies for staff, which are based on their policies.</p> <p>Registered nurses regularly access training, including sessions that are externally run. Bupa run a</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> <p>Bupa has robust quality and risk management systems’, and these are implemented at Cedar Manor, supported by a number of meetings held on a regular basis. Quality improvement alerts are also forwarded from head office to minimise potential risks occurring and the facility is required to complete an action plan. These were covered at Cedar Manor through toolbox talks (sighted) and other documented actions. Education is supported for all staff and 100% caregivers have completed level two Careerforce. Seven are in the process or</p>

	<p>registered/enrolled nurse training day and clinically focused training sessions. Bupa's Dementia Care Advisor acts externally as an advisory to the team and provides on-site training during site visits.</p> <p>The organisation has leadership development of qualified staff education from HR, attendance at external education and Bupa qualified nurse's education day. Nine of the 12 RNs are interRAI trained. One RN has completed PDRP and three RNs are currently working on PDRP. Review of resident files including care plans, interview with residents and relatives, the general practitioner and registered nurses identified competent clinical oversight and support.</p> <p>Bupa newsletters are available for residents and relatives at Cedar Manor. Cedar Manor also provides monthly newsletters for residents and relatives.</p> <p>Several staff initiatives have been implemented including implementing the Bupa SMILE programme that encourages staff to think about their overall wellness.</p> <p>Interviews and documentation reviewed identified that Bupa's robust clinical improvement system is integral to the day-to-day operation of their service, which includes adherence to Bupa policies and procedures.</p> <p>Quality actions have been a focus this year and they have made many</p>	<p>have completed level three.</p> <p>Cedar Manor has been proactive around implementing quality initiatives (Quality action forms), these are established for areas that staff/management identifies as requiring improvement and these are evaluated for effectiveness. There have been a number implemented including (but not limited to); introduction of birthday packs, upgrading old furniture, linens, towels, processes around improving oversight of unsupervised residents, family/resident evening events, and improvements to the environment. The first unannounced Impressions audit conducted May 2017 showed an improvement of 11.2% to 98.2% from the previous year.</p> <p>Cedar Manor has introduced a clinical review meeting 2x weekly that includes management and the registered nurses in duty. This committee reviews any at risk residents, incidents and resident-care concerns.</p> <p>Cedar Manor is proactive around following through and identifying quality improvements from internal audits, incidents/accidents and complaints. QI corrective action plans (CAP) are established when above the benchmark for example, July/August, bruising in the hospital were high, a CAP was implemented, and strategies reviewed each month. The effectiveness of the CAP was evaluated, which identified an improvement in the number of pressure injuries over the next two months. Toolbox talks are routinely completed that link to benchmarking indicators in each of the three areas Cedar Manor.</p>
--	---	--

		improvements to create better outcomes for their residents, the staff and the care home due to these being implemented.	
<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.</p> <p>Audit summaries and action plans are completed as required depending on the result of the audit. Key issues are reported to the appropriate committee (eg, quality, staff, and an action plan) is identified. These were comprehensively addressed in meeting minutes sited.</p> <p>Benchmarking reports are generated throughout the year to review performance over a 12-month period. Quality action forms are utilised at Cedar Manor and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified.</p> <p>There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Cedar Manor is proactive in developing and implementing quality initiatives. All</p>	<p>Cedar Manor is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc.</p> <p>Example: Falls were noted to be high across the service and a quality goal was implemented to reduce falls by 30%. A falls focus group meeting was introduced. This involves the care home manager, clinical manager, unit coordinators, RNs, physiotherapist and three falls champions (who are caregivers from the three areas of the facility). The three residents with the most falls from each area are brought to the table to be discussed. They look at things such as the time the falls happened, what was the resident doing at the time, have there been medication changes, what footwear were they wearing, were they wearing hip protector underwear, any infections which may have contributed to this. Falls prevention strategies have been implemented. Toolbox talks are provided around falls prevention and moving handling with staff at least monthly. Extra drinks rounds' at 11:15 and 15:30 each day in all areas have also been added.</p> <p>On evaluation of the effectiveness of these measures, they have significantly reduced their falls by 30%. In the last 2 months their falls in the hospital area have reduced to five a month. Previous monthly figures were between 17-12.</p>



		meetings include excellent feedback on quality data where opportunities for improvement are identified.	
--	--	---	--

End of the report.