

Heritage Lifecare (BPA) Limited - Telford Home & Hospital

Introduction

This report records the results of a Provisional 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 The DAA Group 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: Heritage Lifecare (BPA) Limited

Premises audited: Telford Rest Home & Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 18 January 2018 End date: 19 January 2018

Proposed changes to current services (if any): The facility is being sold and this provisional audit is being undertaken to establish the prospective owner's preparedness to provide a health and disability service and the current level of conformity with the required standards.

Total beds occupied across all premises included in the audit on the first day of the audit: 31

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.

General overview of the audit

Telford Rest Home and Hospital provides rest home and hospital level care for up to 53 residents – twenty-eight rest home and twenty-five hospital residents. The service is presently operated by Bupa Care Services NZ Limited and managed by a care home manager and a clinical manager. On the days of the audit, there were 31 residents of whom three were younger persons.

This provisional audit was undertaken to establish the prospective owner's preparedness to provide a health and disability service and the level of conformity with the required standards for both rest home and long stay hospital/medical level care. The audit was conducted against the Health and Disability Services Standards and the provider's contracts with the Taranaki District Health Board (TDHB). The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau members, management, staff, a general practitioner, and the prospective owner.

This audit has resulted in nine areas requiring improvements. These relate to corrective action planning, orientation records, first aid training/certificates for staff to cover all shifts, performance appraisals, effective medication administration and self-administration of medicines, processes for preventative maintenance and biomedical testing, a hazard in the external environment,

laundry processes, and emergency supplies. Improvements have been made to hot water temperature monitoring, care planning, and timeliness of interRAI assessments, which address three of five areas requiring improvement at the previous audit.

Consumer rights

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Bupa have developed business and quality and risk management plans outlining the goals and values of the organisation. Monitoring of Telford Rest Home and Hospital provides effective information to the wider organisation to assist in regular monitoring of its performance. An experienced and suitably qualified care home manager has been in the role for a year.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and engaged in improvement activities and feedback is sought from residents and families.

Adverse events are documented in a newly introduced electronic system. Actual and potential risks, including health and safety risks, are identified and mitigated. Current policies, procedures and records support service delivery.

The appointment, orientation and management of staff is based on current good practice and supported by a national human resources team. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

Continuum of service delivery

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are managed and administered by staff who have completed a medication competency to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

The facility meets the needs of residents and was clean. There is a current building warrant of fitness. There are records of electrical and biomedical equipment testing being undertaken. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible to residents with mobility aids and seating and shade is available.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and is evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Two restraints were in use, with restraint use reducing over time. A comprehensive assessment, approval and monitoring process is in place with regular reviews occurring. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	44	0	3	3	0	0
Criteria	0	92	0	6	3	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 facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff and include advance care planning, establishing and documenting enduring power of attorney requirements. Processes for residents unable to consent are defined and documented. Clinical files reviewed showed that informed consent has been gained using the organisation's standard consent form. One resident admitted in October 2017 did not have the general consent signed until the day of audit. Documentation showed that the resident's family were asked and were provided with the consent form on several occasions. Where a resident is deemed incompetent to make</p>

		an informed choice the enduring power of attorney (EPOA) will consent on behalf of the resident. Staff were observed to gain consent for day to day care.
<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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The acting clinical manager was able to provide examples of when the Advocacy Services would be encouraged.</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 are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed 23 complaints were received over the past eight months. Several complaints were received in the middle of 2017, but these have reduced noticeably in the past four months. Most complaints related to the telephone system, food and staff attitude. Actions have been taken, through to an agreed resolution. These are documented and completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible. The Care Home Manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. A complaint to the Taranaki District Health Board (TDHB) in relation to a recent scabies outbreak has been satisfactorily concluded. There are no known Health and Disability Commissioner complaints or complaints</p>

		received from external sources since the previous audit.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in the main foyer of the facility together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>The prospective provider is an experienced aged care sector provider. Existing clinical staff have a good understanding of the requirements of the Code as part of their current roles.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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 home care manager interviewed stated that there are currently no residents who affiliate with their Maori culture. There are no barriers in supporting residents who are admitted to the facility who identify as Māori, with staff able to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi as documented in the policy are incorporated into day to day practice, as is the importance of whanau. There is no</p>

		specific current Māori health plan, however all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and evidenced in the care summary, 'map of life', identified in the interRAI assessment and integrated into long-term care plans with input from cultural advisers within the local community, who also provide guidance on tikanga best practice.
<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	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. One of four general practitioners who work at the service interviewed confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed, and the use of family members. The acting clinical manager interviewed stated that there are several residents who are unable to verbally communicate their needs. The staff know the residents well and are able to respond to the residents' non-verbal cues appropriately and support the residents' needs.</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>Telford Rest Home and Hospital provides hospital (geriatric and medical) and rest home level care for up to 53 residents. On the day of audit, there were 22 rest home level residents of whom three are under the residential disability contract and nine hospital level residents receiving hospital level care. Respite care residents are also accepted when there is bed availability.</p> <p>Bupa operates with a defined vision and goals which are clearly promoted in the facility. Annual goals are established each year, with 2018 goals under development and awaiting approval. The service is currently managed by a care home manager appointed to the role in February 2017. She is a registered nurse with extensive experience, including with a DHB, clinical services and management of rural community facilities with aged care beds. She holds a master's degree in nursing, post graduate diploma in health service management and a post graduate certificate in emergency management.</p> <p>She is supported by a Bupa relieving clinical manager/registered nurse (RN) since the resignation of the previous clinical manager in early January 2018. Both the care home manager and clinical manager are</p>

		<p>supported by a Bupa regional manager. On call arrangements are shared between the care home manager and clinical manager. The care home manager advised that an experienced registered nurse has been recruited to the clinical manager role and is awaiting completion of the employment process. The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service through the Bupa leadership programme and other external courses. She regularly participates in the Bupa group teleconferences.</p> <p>The new provider is Heritage Lifecare Ltd (HLL) which is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). Telford Rest Home and Hospital is one of twelve proposed facility acquisitions across the country.. As of 30 January 2018 HLL, has set up a new company to acquire and operate this group of new facilities. This company is Heritage Lifecare (BPA) Ltd. However, for ease of reference the new provider is referred to as Heritage Lifecare Limited (HLL) throughout this report.</p> <p>The transition plan is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facilities into the Heritage Lifecare Ltd group. This includes provision of infrastructure support, such as providing information technology capability including hardware and software. Regional workshops are planned to introduce documentation, and the new HLL systems and processes. This is planned to occur within the first three months. The project team is working with the BUPA team to ensure a smooth transition of each operation. The senior team is expected to remain at the facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During the temporary absence of the care home manager, the clinical manager carries out all the required duties under delegated authority. There is also the option of support from a Bupa roving manager or a care home manager from another Bupa site located in New Plymouth.</p> <p>The prospective provider is not planning any staffing changes. Existing cover arrangements for the day to day operations will remain in place, with</p>

		<p>access to regional operations managers. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC manager to meet section D17 of the agreement.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The organisation has a planned and implemented quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint use.</p> <p>Quality and risk data, including trends in data and benchmarked results are discussed in registered nurse, staff and quality risk/health and safety meetings and reported monthly in the managers' report. Emerging issues are also discussed each week at a managers' teleconference. Facility meeting minutes confirmed regular review and analysis of quality indicators such as falls, pressure injuries, health and safety, restraint use and infections. Information, including audit results, are reported and operational matters discussed at these meetings attended by management, staff and registered nurses. Staff also report their involvement in quality and risk management activities by undertaking audit activities. Relevant corrective actions are planned and implemented to address any service shortfalls, however, these are not always system focussed (see criterion 1.2.3.8). Examples include plans to address an increase in infection rates and falls (clinical) and actions to address phone issues (complaints). Resident and family satisfaction surveys are completed annually, with feedback used to plan improvements. The 2017 survey identified telephone issues, food and outings as areas of concern. All have been addressed.</p> <p>An annual internal audit plan/schedule and audit results evidences internal audits are planned to occur on a regular cycle and are linked to specific problem areas. On occasion, audit frequency is increased to monitor that the corrective action has addressed the problem.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term</p>

		<p>Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. A nationally implemented document control system ensures systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. One hard copy folder of all documents is available in the facility, with all master documents held electronically.</p> <p>The care manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented on site requirements.</p> <p>The new provider confirmed that during the transition phase, HLL policies and procedures will be introduced. By the end of 2018, a new software system will be introduced to incorporate risk management which includes adverse event reporting, care planning and client management. Meanwhile, the electronic BUPA system will be superseded by HLL documentation and will be reliant on hard copies on site until the electronic system is fully implemented. This is anticipated to be within six months of the purchase.</p> <p>HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. A key strategy to introduce a national clinical governance group is planned in the next 12 months.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>In November 2017, the national electronic risk management system was introduced to the Telford Rest Home and Hospital site. It is used to capture and analyse adverse and near miss events. Information about any adverse event is entered into the system, along with any subsequent actions or follow up. Facility adverse event data is collated and trended over time and reported each month to Bupa. Reports sighted highlight any areas which are above the national benchmarks or there is a variance since the previous report. Family are routinely notified following clinical</p>

		<p>incidents and this is recorded in the clinical record and electronic system.</p> <p>The care manager described essential notification reporting requirements. An event in December 2017 has been documented and reported using a section 31 notification to the MoH and District Health Board. There have been no other notifications of significant events made to Worksafe NZ, professional bodies, police or the Coroner since the previous audit.</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The national quality manager interviewed could verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements for event reporting.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Bupa human resources management policies and processes are based on good employment practice and relevant legislation for the recruitment and selection of staff. The recruitment process includes referee checks, police vetting and validation of qualifications and practicing certificates (APCs), where required. A sample of eight staff records confirms the organisation's policies are being consistently implemented and records including signed job descriptions and employment contracts are maintained. Some personnel files are yet to systematically organized.</p> <p>Staff orientation includes all necessary components relevant to the role. Caregivers undertake the standard Bupa induction which provides the staff member with a Foundation NZQA level 2 qualification at the end of their three-month orientation period. Registered nurses are initially supernumerary. Other staff groups also have specific structured orientation programmes. Not all staff reported that the orientation process had prepared them well for their role and some gaps in 2017 orientation records are noted. An annual performance review system is in place, with efforts made to complete the 2017 schedule. All but two staff have been booked to catch up overdue appraisals at the time of audit. A register of registered nursing staff and other health practitioner practicing certificates is maintained.</p> <p>Bupa plan continuing education on an annual basis, including workshop sessions for some of the compulsory and core training requirements.</p>

		<p>Specific topics are added where deficits are seen. Attendance at mandatory training can be demonstrated through the attendance register maintained for each training session. Some staff have an individual annual record of training on file. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>An annual competency, including individually completed workbooks where appropriate, is implemented – examples included moving and handling, restraint, and workplace first aid or equivalent (see criterion 1.2.7.5). Competencies for registered nurses include medication, catheter care, wound management and syringe drivers. Records are maintained. Household staff also undertake regular relevant education (eg, infection control and moving and handling). Presently, there is no internal assessor for the unit standard based programme. Other education is provided with ‘toolbox’ talks and regional education is provided by the local Hospice and the Taranaki DHB. Offsite education sessions are also attended by many care and registered staff.</p> <p>There are currently two registered nurses who are maintaining their annual competency requirements (sighted) to undertake interRAI assessments. The care home manager states the intention is to train all the current registered group to competency following a period of registered nurse turnover. There is currently no uptake of the Bupa professional development and recognition programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. A retrospective tool, which is updated fortnightly, provides data in relation to staffing hours used by staff type was reviewed. This meets contractual requirements, however there is presently no link to the acuity levels identified in the interRAI tool.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. The care manager states there has been some adjustment to staff hours due to low occupancy. Presently, this has impacted on afternoon shift staffing in the rest home with one care staff member covering up to 18 residents across two wings. The care home manager reports that there</p>

		<p>will be a short shift introduced to provide better cover due to a change in condition and the need for very regular monitoring of one resident. This is an interim measure, as the resident was referred for urgent medical review and psychogeriatric assessment on the day of audit. Residents and family interviewed felt staff were responsive to call bells.</p> <p>There is 24 hour/seven days a week (24/7) RN coverage in the hospital. They are also available to the rest home staff for advice and support when the clinical manager is not on site. Observations and review of a two-week roster cycle (covering the past six weeks including the holiday period) confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. On occasion, this means staff working longer shifts than originally rostered. Care staff have a mix of eight-hour shifts, with several shorter shifts used to cover busy periods. Household staff operate a separate roster. Four of six registered nurses, five care staff, the maintenance person and activities coordinator hold a current first aid certificate, however this does not currently cover all shifts or shift duration (see criterion 1.2.7.5).</p> <p>The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the indicators for safe staffing level. The representative for HLL interviewed could confirm understanding of the required skill mix to ensure rest home and hospital/medical care residents' needs are met. As an organisation, HLL already provides a range of care levels (geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services. It is experienced in delivering the levels of care currently provided by Telford Rest Home and Hospital.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>The latest archived records are held securely on site and are readily</p>

		<p>retrievable using a cataloguing system. The home care manager interviewed stated that the organisation holds older records of site and in a secure building not able to be viewed at time of audit.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information (verbal and written) that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example of a patient transferred to the local acute care facility showed the use of the 'yellow envelope' and supportive documents. Family of the resident reported being kept well informed during the transfer of their relative.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are deemed competent to perform the function they manage; however, on the day of audit medication administration processes were observed not to be undertaken in accordance with organisational policy.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There are residents who self-administer medications at the time of audit, however not all appropriate processes are in place to ensure this is managed in a safe manner. There is an implemented process for comprehensive analysis of any medication errors.</p> <p>The previous audit identified four areas of non-compliance. The correction actions are now addressed due to the implementation of the medication management electronic system implemented at the facility on the 4 April 2017. All residents have been seen by the GP at least three-monthly for reviews, the facility has discontinued standing orders for</p>
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		medication and all allergies are documented in clinical notes. All records were available to demonstrate this.
<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>The food service is provided on site by two cooks and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the local council and expires 22 September 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The home care manager interviewed stated that there were no examples of residents being declined to the service. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. There is a clause in the access agreement related to when a resident's</p>

		placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, challenging behaviours and depression scale, to identify any deficits and to inform care planning when the resident is initially admitted to the facility. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of two trained interRAI assessors on site. The acting clinical manager interviewed stated the intention is to train all registered staff at the facility to complete interRAI. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant meeting both the physical needs and health needs of the residents both younger and older. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. The previous audit identified three areas of non-compliance. The correction actions are now addressed, and records were available to demonstrate that all interventions are documented in resident's progress notes and as a result short term care plans are developed and when closed this information is then updated in the resident's long term care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's</p>

<p>to meet their assessed needs and desired outcomes.</p>		<p>individualised needs both young and older was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs within the facility and while out in the community.</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>The activities programme is provided by an activity co-ordinator who works 30 hours a week and holds the national Certificate in Diversional Therapy. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Younger persons with disabilities are encouraged to maintain community links such as day care, gardening and other community group activities held. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive and are encouraged and supported to maintain connections within the community.</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>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for</p>

		unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<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	Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the physiotherapist, hospice, and clinical nurse specialist. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
<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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Waste management removal is contracted to an external provider, with general waste collected from the site twice weekly. Appropriate signage is displayed where necessary.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Records of training confirms that this occurs. Chemical and blood spills kits are available. Chemicals are all labelled correctly</p> <p>The cleaners have a locked cupboard to store the cleaning trolleys when they are not in use. Material safety data sheets are available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment, staff understood its use and were observed using this appropriately.</p>
Standard 1.4.2: Facility Specifications	PA	A current building warrant of fitness (expiry date 20 July 2018) is publicly

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>Moderate</p>	<p>displayed.</p> <p>There is a BUPA wide maintenance system which is implemented locally on the 52-week schedule as required. A new maintenance person for 30 hours per week was employed in November 2017 to undertake this work and any day to day maintenance or repairs required. He is still in the orientation period and has identified several opportunities to improve systems and processes in relation to maintenance. However, there are presently aspects of maintenance that require attention (refer criteria 1.4.2.1 & 1.4.2.4).</p> <p>The testing and tagging of electrical equipment and calibration of biomedical equipment is up to date following inspection of the facility environment and equipment. However, the system to maintain these records requires improvement. Hot water temperature testing occurs regularly with temperatures maintained within safe limits below 45 degrees Celsius. Suitable facility and individualised equipment is available to provide the required level of care.</p> <p>The facility is on a sloping site. It is appropriate to the needs of the resident groups and setting. There are sealed car parking areas and paths. Shade is available in outdoor areas, lawns and courtyards. Not all areas promote independence or are safe (see CAR. 1.4.2.4). The service has a leased van with a hoist available for use on outings or medical appointments.</p> <p>Residents confirmed the environment is homelike and comfortable, and maintained at a pleasant temperature.</p> <p>HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are presently no plans for any environmental changes in the facilities.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Most rest home rooms share toilet facilities between two rooms. Privacy locks are fitted. Bathrooms are located close to resident lounge areas, or bedrooms. One hospital room has an individual ensuite. In total, twenty-three rooms have individual or shared toilet facilities, which have appropriately secured and approved handrails.</p>

		<p>There is additional equipment available – commodes, a bath trolley and shower chairs. Showers and toilet areas are in good repair with easy to clean, intact surfaces.</p> <p>Toilets are clearly designated with signage. Vinyl flooring has been installed for ease of cleaning.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation and have room to facilitate the safe use and manoeuvring of mobility aids. Rooms are personalised with furnishings, photos and other personal items displayed. Hospital rooms have one third/two third doors to facilitate bed movement.</p> <p>There is sufficient storage for mobility aids, wheel chairs and mobility scooters which are managed safely. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities in the rest home. Residents can access various areas for privacy, if required. There are separate dining areas. The dining rooms are spacious and provide easy access for residents and staff. Furniture is appropriate to the setting and residents' needs.</p> <p>The lounge spaces for hospital residents are very small. Presently there are only nine residents using this area, most of whom use large chairs or wheelchairs and all require close monitoring by staff. Greater occupancy in the facility would add significant pressure to this area. Alternative areas are available for mobile residents.</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>	PA Low	<p>Laundry is undertaken on site in a separate suitably equipped laundry. Staff interviewed are experienced with knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. However, not all aspects of laundry processing are clearly understood (see criterion 1.4.6.2). Residents interviewed reported the laundry is managed well and</p>

		<p>their clothes are returned in a timely manner.</p> <p>Household staff have received appropriate training; however, the level 2 cleaning certificate is not currently being offered. One staff member interviewed has a dual role in cleaning and laundry activities (refer also 1.2.7.4).</p> <p>Chemicals are stored in a locked cleaning room in appropriately labelled containers. Safety data sheets and personal protective equipment are readily available and seen to be used by staff.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. Any issues are identified and managed through a corrective action process.</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>PA Low</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides are available. The current fire evacuation plan was approved by the New Zealand Fire Service on the 12 February 2014. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in August 2017. A staff response to a fire activation in December 2017 has been commended by the fire service. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Supplies for use in the event of a civil defence emergency requires some further action to ensure the content is adequate for a period of three days (see criterion 1.4.7.1). There is sufficient food on hand for the number of people in the facility. A water storage tank is located on site but requires treatment to be potable. Additional supplies are stored for immediate use. There is emergency lighting and gas cooking is available in case of power outages. There is no generator on site.</p> <p>Call bells alert staff to residents requiring assistance with alerts going to the pager, phone or visual display. Call bells are on hand in all resident areas. Call system response times are monitored and have improved following survey feedback. The diversional therapist and maintenance person taking residents off site have current first aid certificates.</p> <p>Appropriate security arrangements are in place. Doors and windows are</p>

		locked at a predetermined time and a contracted security company checks the premises at night.
<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 residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and there is access to the garden and courtyards from hallways and a conservatory. There are heat pumps/air conditioning in the communal areas.</p> <p>Residents and families report that temperatures are maintained at a comfortable level. Records are maintained of the ambient room temperatures on a weekly basis and are in the recommended range. There is a designated external smoking area.</p>
<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 service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the organisation's operations manager who is a registered nurse and quality services improvement team. The infection control programme and manual are reviewed annually.</p> <p>The acting clinical manager is currently the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported at the monthly infection control meeting and staff meetings. This committee includes the home care manager, IPC coordinator, the health and safety officer, and representatives from food services and household management.</p> <p>Staff discourage visitors from visiting the facility when unwell. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
Standard 3.2: Implementing the infection control programme	FA	The IPC coordinator/acting clinical manager has appropriate skills,

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>knowledge and qualifications for the role. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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 prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2017 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices, however at the time of audit not all staff interviewed were able to communicate and/or demonstrate fully their understanding of infection control and appropriate use of equipment in regards to laundry (please see criterion 1.4.6.2).</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>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, eye, gastro-intestinal, the upper and lower respiratory tract, wound infections and others (eg, scabies). The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the facility and clinical manager and the organisation. The facility is benchmarked externally with 65 other facilities within the organisation. In the Month of August 2017 seven residents were diagnosed with a urinary tract infection and eight residents with a respiratory tract infection and prescribed antibiotics. A corrective action put into place and interventions implemented showed a positive result and reduction in urinary tract infections of six residents in September and in October 2017 reduced further to two. Respiratory tract infections were also reduced to two in September 2017.</p> <p>A summary report for a recent scabies outbreak in June/July 2017 was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Bupa policies and procedures meet the requirements of the restraint minimisation and safe practice standards and include definitions and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the acting clinical manager. She provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and responsibilities. There is a regional restraint group with terms of reference. A job description describes responsibilities</p>

		<p>of the restraint coordinator for the role.</p> <p>On the day of audit, two hospital residents were using restraints (lap belt and bed rails) and no one using an enabler. Restraint use is recorded in the restraint register. The restraints used are the least restrictive and implemented following appropriate assessment and discussion. Assessment, monitoring and evaluation are consistently completed. These residents have only recently had restraint interventions and not yet had a formal review undertaken. A similar process is followed for the use of enablers. Restraint is included in the annual compulsory training days for clinical staff.</p> <p>Restraint is used as a last resort when all alternatives have been explored. Restraint is a standing agenda item at the monthly quality meeting. Use of restraint and enablers is also reported nationally, benchmarked and reviewed as part of the monthly clinical indicator report. The two files reviewed of residents currently using a restraint, interview with staff and the restraint coordinator confirmed the processes are consistently implemented in accordance with the standard.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The regional restraint approval group, are responsible for the restraint processes for the Bupa group. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed in the facility. Minutes of the scheduled restraint teleconference were sighted for June 2017, with evidence of discussion and good practice opportunities.</p> <p>Evidence of family/whānau/EPOA involvement and agreement in the decision making was on file for the two residents using restraint. Use of a restraint or an enabler is part of the plan of care and is documented in the interRAI tool at the next assessment. Neither resident has used restraint long enough for this to occur. Approved restraints for the organisation are lap/T belts, bed rails, table top chairs, ultra-low beds, fall out chairs and bean bags.</p> <p>One resident has had restraint (bed rails) implemented following hospitalisation and falls in hospital. Its use is monitored closely and</p>

		ongoing discussion with the resident and family/whānau are evident in the resident's record. This is a new restraint, with good examples of alternative strategies trialled to reduce the length of time the resident required the intervention.
<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	A standard restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, and in consultation with the general practitioner, the resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Response to restraint is also documented in the two cases sampled.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, such as the use of sensor mats and ultra-low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe – frequency of monitoring reflects the type of device and assessed risks. Records of monitoring sighted had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained both residents currently using a restraint. There is sufficient information included to provide an auditable record of use.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
Standard 2.2.4: Evaluation	FA	Review of residents' files showed that the individual use of restraints is reviewed and evaluated on an ongoing basis. Neither resident using

<p>Services evaluate all episodes of restraint.</p>		<p>restraint has yet had a formal review undertake, however, there is evidence in the plans of care of reporting on the response to restraint. Restraint has been added to the care plan in both cases. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the respectful manner in which restraint is used.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy has been followed and documentation completed as required.</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>	<p>FA</p>	<p>The Bupa national restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard, including trends and progress to minimisation of restraint. Bupa uses results from benchmarking across the group to identify trends in restraint use, with minimisation and elimination of the intervention where possible.</p> <p>Restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed discussion includes analysis and evaluation of the amount and type of restraint used in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education. There are regional restraint group meetings (held via teleconference) to monitor use and complete the quality review of restraint. Any learning is disseminated to the wider group of facilities. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the restraint coordinator and the clinical manager confirmed that the use of restraint has been reduced year on year. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective action plans are developed in response to clinical indicators, audit results and incidents. A new electronic system has been introduced to the facility to capture the adverse events. Corrective actions are included where appropriate, however, these largely reflect short term actions and responses to the problem. Examples include the recent fire where suitable actions had been taken in response, but the contributing factors were not considered as part of the follow up actions. A second example linked to this issue is still to be addressed. Corrective actions are closed in a defined time frame.</p>	<p>Corrective action planning does not consistently include a review of the system or process issues which may have contributed to the event.</p>	<p>Consider the impact of system and process issues when planning corrective actions to address problems.</p> <p>180 days</p>
Criterion 1.2.7.4	PA Low	In three of eight files reviewed, there is	Orientation records are	Ensure orientation

<p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>		<p>incomplete records of induction, including when the staff member changes and/or adds a new role. Staff interviewed indicated that induction did not always fully prepare them for their role (eg, a newly appointed activities coordinator felt inadequately prepared for the scope of their role. There is no file record of them completing orientation in 2017). At least one other staff member does not have an orientation record on file. Another staff member has an orientation record for one role, but not the second role they fulfil.</p>	<p>incomplete in the files sampled.</p>	<p>records are completed and filed in the personnel records.</p> <p>180 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>Seventeen (of 44) staff performance appraisals were seen to be overdue as at the end of 2017. All except two staff have completed their appraisal or are now booked an appointment to complete this before February 2018.</p> <p>Over the past nine months, there has been significant turnover of registered, care and household staff, including the clinical manager. There is an education plan and competency programme for staff, including first aid certification. On the day of audit, four of six employed RNs had current first aid certificates and five caregivers working in both the rest home and hospital. The maintenance and activities coordinator, who take residents off site, have recently completed the course. However, first aid competency does not fully cover all shifts or periods during shift times over the 24 hours. Training is scheduled with an external provider for the 22nd January, with 19 staff booked for the on-site course. All</p>	<p>Performance appraisals are not fully up to date, with a six of the seventeen-staff overdue still to complete their appraisal. Four of the six staff are booked for this. Not all shifts or parts of shifts are covered by staff holding a current first aid certificate.</p>	<p>Complete all performance appraisals by the due date. Ensure that all shifts are covered by first aid competent staff.</p> <p>90 days</p>

		registered nurses, activities personnel and maintenance staff are expected to hold current first aid certification.		
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>All registered staff administering medication have an up to date medication competency. A registered nurse interviewed was able to demonstrate good hand hygiene and security of medication while reviewing the treatment/medication room; however a registered nurse completing a medication round was observed to not wear the provided medication apron, did not have access to hand gel on the medication trolley, did not have the unlocked medication trolley in eyesight at all times, did not wash hands before or after the entering of a resident's room, and used hand gel only prior to administering eye ointment to two individual residents.</p>	<p>Medication administration processes were observed not to be undertaken in accordance with the organisational policy in relation to hand hygiene or security of the medication trolley.</p>	<p>Ensure that all staff administering medications comply with the organisation's policies and protocols.</p> <p>90 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>One resident had an assessment completed to assess for competency of self-administration of medication. The assessment was signed by the admitting RN and GP at the time, and subsequent assessments have been completed three monthly. The RN has evidenced that the resident is asked each morning if they have taken their medication and this was recorded. Observation on day one of the audit, showed that a further three residents were storing their medication in unlocked draws in their rooms and had not had an assessment to show competency. In</p>	<p>Three of four residents self-administering medication did not have an assessment to show competence to do so, or had their medications stored in a locked box.</p>	<p>Provide evidence that all residents who are self-administering medicines are meeting the facility's policy requirements to do so safely.</p> <p>180 days</p>

		discussions with the residents and staff it was evident that the residents are competent in the self-administering of their medication and evidence was provided to show three-monthly GP reviews that included review of the resident's medication.		
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA</p> <p>Moderate</p>	<p>Bupa Telford Rest Home and Hospital has an external contract for preventative and remedial maintenance and cleaning and calibration of biomedical equipment.</p> <p>a) A report for 2016 and 2017 was sighted. There is a significant discrepancy in the equipment content listed between the two reports, with multiple items of equipment listed in the latest report that does not appear to be used on site (eg, ECG, tympanometry, baby scales and electro-surgical generators). This has not been queried.</p> <p>b) There is no clear system to add new or remove obsolete items from the list of equipment being checked by the contractor or that ensures the equipment presented for checking is complete. A random selection of on-site equipment verified that validation stickers had been attached to equipment - these are due to be retested in March 2018.</p> <p>c) Testing and tagging is undertaken as required. However, the system does not ensure that equipment brought into the facility by residents is included on to the list for electrical testing (or removed from the</p>	<p>A system is implemented for preventative and remedial maintenance and cleaning and calibration of biomedical equipment. However, this does not ensure accurate, complete and current information is provided to the contractor, nor that all equipment outside the testing period is captured.</p>	<p>Implement a comprehensive and robust system for electrical testing and tagging and for validation and calibration of biomedical equipment.</p> <p>90 days</p>

		list) in a timely manner. In one recent example, a fire occurred in a resident's microwave that had not been approved for use, not included in the testing programme nor had an out of cycle testing process implemented.		
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	<p>The external environment includes an area underneath the main building where a new gas boiler and two cylinders have recently been installed and commissioned. This has required some excavation of the adjacent area which has left a pile of stacked rubble (earth and concrete) located next to the boiler. This has not been isolated or made safe. The area is used by contractors for waste management and by staff accessing the building from the ground level.</p> <p>There are at least two areas in the rest home where there are sloping floors or noticeable dips underneath both carpet and vinyl. This creates a trip hazard for residents and staff.</p>	Not all areas of the facility minimise the risk of harm to residents and staff. There is an unsafe accessible area at ground level under the building and uneven floor levels in the rest home.	<p>Ensure all areas of the facility minimise the risk of harm for users.</p> <p>180 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	PA Low	<p>There is no readily available guidance for staff to follow on the use of the ten different wash cycles. Temperatures of loads are now being monitored and recorded daily, however, it is unclear what the levels of acceptable variance are for the load being monitored, or the expected actions if loads do not reach the required temperatures. A 2017 infection outbreak reviewed the laundry process but did not consider the correct choice of the wash cycles or</p>	Laundry policies guide practice for laundry staff. However, there is no readily available information to guide staff on acceptable wash temperatures or content for each load type.	<p>Provide information for staff who monitor the variance in wash load temperatures and guidance on determining the type of load.</p> <p>180 days</p>

		temperatures as a possible factor in the transmission of the infection in the facility.		
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Low	<p>There is sufficient food for three days in an emergency, but other emergency supplies and equipment on hand are limited. The kit sighted does not contain all necessary items (eg, water purification tablets) or sufficient potable water to cover at least three days. The care manager has identified these inadequacies and improving the supplies is a work in progress.</p>	<p>There are insufficient emergency supplies on hand in the event of an emergency.</p>	<p>Provide and maintain sufficient emergency supplies to cover the operation for at least three days.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.