Bupa Care Services NZ Limited - David Lange Care Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	David Lange Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 7 February 2018 End date: 8 February 2018
Proposed changes to current services (if any):	

Total beds occupied across all premises included in the audit on the first day of the audit: 84

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

David Lange Care Home is part of the Bupa group of aged care facilities. The care facility has a total of 87 beds certified for rest home, hospital and residential disability (physical) levels of care. During the audit there were 83 residents at the facility.

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 service is managed by an experienced management team. The care home manager is supported by a clinical manager, unit coordinators and a Bupa regional manager.

The residents and relatives interviewed all spoke positively about the home, staff and the care provided.

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who live in the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to David Lange and has been embedded in practice. Quality initiatives are implemented which provide evidence of improved services for residents.

There are improvements required by the service around orientation, training, integration of care documentation, care plan interventions, medication documentation and restraint monitoring.

A continued improvement rating has been awarded around the food service and meeting the needs of multi-cultures.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

The service complies with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights. Staff strive to ensure that care is provided that focuses on the individual resident, values residents' autonomy and maintains their privacy and choice. Cultural needs of residents are being met in this culturally diverse setting. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

The care home manager is supported by a clinical manager; unit coordinators, registered nurses, caregivers and support staff.

The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk

management processes and results. Resident and family meetings are held, and satisfaction is monitored via annual satisfaction surveys.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

Appropriate employment processes are adhered to. An education and training programme is established. The roster provides sufficient and appropriate staff cover for the effective delivery of care and support.

The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

There is a comprehensive admission package available prior to or on entry to the service. Resident records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. Resident files include one – three monthly reviews by the general practitioners. There is evidence of other allied health and specialist input into resident care.

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

An integrated activities programme is implemented for all residents. There is also a specific programme for the younger people. The programme includes community visitors and outings, entertainment and activities that meets the recreational preferences and abilities of the residents.

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

Chemicals are stored securely throughout the facility. The building holds a current building WOF. Resident rooms are single, spacious and personalised. All rooms, ensuites and communal bathrooms are large enough for mobility equipment. There is a mobility bathroom with shower on each floor. Communal areas within each area/community are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant. Electrical equipment has been tested and tagged. All medical equipment and hoists have been serviced and calibrated. Hot water temperatures are monitored.

Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.

Restraint minimisation and safe practice policies and procedures are in place. There were two residents using restraints and nine residents using enablers during the audit. A registered nurse is the designated restraint coordinator. Staff are offered training in restraint minimisation and challenging behaviour management, which begins during their orientation to the service. Staff are also expected to complete a restraint minimisation competency annually.

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)
Standards	0	45	0	3	2	0	0
Criteria	1	94	0	4	2	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) policy and procedure is implemented. Discussions with the care home manager, clinical manager/RN, and eighteen care staff (eight caregivers who are responsible for rest home and hospital level residents during the morning, afternoon and night shifts), two-unit coordinators/registered nurses (RNs), four staff RNs, one activities coordinator and three activities assistants) confirmed their familiarity with the Code. Interviews with twelve residents (one young person with a disability (YPD), six rest home and five hospital) and seven relatives (one YPD, three hospital, three rest home) confirmed that the services being provided are in line with the Code. Aspects of the Code are discussed at staff and resident meetings.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give	FA	The service has in place a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There were signed general consents including outings in all 10 resident files reviewed. Resuscitation treatment plans, and advance directives were completed in the files reviewed. Discussions with caregivers, and registered nurses (RNs) confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms.

informed consent.		Discussion with relatives confirmed that the service actively involves them in decisions that affect their relative's lives. Informed consent processes were also being reviewed through the six-monthly MDT meeting with residents and relatives and also links to the quality system through satisfaction surveys and internal audits.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There is a policy that describes the role of advocacy services. Staff receive training on advocacy. Information about accessing advocacy services is available in the information presented to residents and their families during entry to the service. Four resident advocates have been appointed to assist with advocacy for residents from other cultures (e.g., South Asian, Maori, Pacific Island). An interview with one resident advocate confirmed their role in supporting the residents. Interviews with staff, residents and relatives confirmed that they were aware of the availability of advocacy services and how to access an advocate. The complaints process reminds the complainant of their right to contact the health and disability advocacy service with contact details provided.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to be involved in community activities and maintain family and friend's networks. Care staff interviewed confirmed that residents are encouraged to build and maintain relationships. Visiting can occur at any time. Community links were evident and included (but were not limited to) local churches and the local schools. The service is responsive to young people with disabilities accessing the community, resources, facilities and mainstream supports such as education, public transport, and primary health services in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaint register. Eight complaints were received in 2017. Seven of the eight complaints indicated in the complaints register that they were closed following an investigation. Timelines determined by HDC were met, and corrective actions (where indicated) were actioned. The complainant

		was kept informed throughout the complaints process. One complaint, lodged with the DHB in December 2017, remains under investigation by the DHB. A response letter outlining an investigation has been sent to the DHB. Corrective actions have included development of a referral flow chart to streamline referrals for allied health services and the establishment of a health services agreement with the allied health service identified in the complaint. Complaints are discussed in quality meetings. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There are posters displaying the Code. The service is able to provide information in different languages and/or in large print if requested. On entry to the service the RN responsible for admitting the resident discusses the Code with the resident and the family/whānau. Information is given in the information pack to the resident, next of kin or enduring power of attorney (EPOA) to read and discuss.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. During the audit, staff were observed gaining permission prior to entering residents' rooms. All care staff interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents' cares. Residents and family members interviewed confirmed that staff promote the residents' independence wherever possible and that residents' choices are encouraged. Ten double rooms are located across all three levels of the facility. A curtain between the two beds provides visual privacy. Two residents interviewed (one Indian speaking resident who shares a room with another Indian speaking resident and one resident who shares a room with his wife) commented that they were satisfied with the arrangement. Young people with disabilities are able to maintain their personal, gender, cultural, religious and spiritual identify, evidenced in one YPD resident interviewed and one file reviewed of a YPD resident. There is an abuse and neglect policy that is implemented, and staff have undertaken training on abuse and neglect (link 1.2.7.5).
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and	FA	The service has established Maori cultural policies to help meet the cultural needs of its Maori residents. Bupa has developed Maori tikanga best practice guidelines, which are posted in visible locations. Linkages to local iwi and community members have been established and are documented for staff to access.

disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		There were three residents who identified as Maori. One Maori resident is a designated resident advocate. One Maori resident interviewed confirmed that their cultural needs were being met. The needs of the Maori residents are identified in their individual resident file (e.g., individual cultural assessment, care summary, map of life, 'my day/my way' documentation). Interviews with multicultural care staff (e.g., Maori, Pacific Island, Indian, Asian) confirmed their understanding of Maori cultural values and beliefs with examples provided including (but not limited to) the importance of whanau.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service has established cultural policies aimed at helping to meet the cultural needs of its residents. The residents and staff are from a range of countries including (but not limited to) South Asia and the Pacific Islands. Staff and residents assist with translation. The service has strong links with specific church groups and a relationship with the Bhartiya Samaj Charitable trust. All residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values is used to develop a care plan which the resident (if appropriate) and/or their family/whānau are asked to consult on. Cultural preferences are also identified in the resident's map of life and 'my day/my way' documentation. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. Foods are offered to meet the cultural needs of residents with up to four different menus provided throughout the week. The activities programme celebrates the cultural diversity of the facility. Links are identified with specific church groups and the local community.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with all staff 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. The service receives support from the district health board which includes visits from specialists (e.g., nurse practitioner and mental health services). Physiotherapy services are provided three day per week. Education and training for staff includes in-

		service training and competency assessments (link 1.2.7.5). Quality initiatives implemented in 2017 have included enhancing communication amongst the managers and unit coordinators though the development of a new model of communication, enhancement of the activities programme, improved access to linen and a new menu system that offers up to four different menus and has addressed previous residents' complaints around food choice. Podiatry services and hairdressing services are provided. The service has links with the local community and encourages residents to remain as independent as possible.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. A record of family communication is held in the front of each resident's file. Regular resident meetings provide a venue where issues can be addressed. Fifteen incident/accidents forms were randomly selected for review indicated that family were informed. Families interviewed confirmed they are notified of any changes in their family member's health status. Interpreter services are available if needed. Staff, residents and family are utilised in the first instance with the rostering system ensuring that residents who do not speak English have staff available on each shift to assist with communication.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	David Lange Care Home is part of the Bupa group of aged care facilities. The care facility has a total of 87 beds suitable for rest home, hospital and residential disability (physical) levels of care. Hospital level of care is certified for geriatric and medical. During the audit there were 83 residents at the facility (38 rest home (including two respite and one long term chronic conditions (LTS-CHC)), 45 hospital (including four YPD, one primary options acute care (POAC), and 4 LTS-CHCH). One resident (hospital) was in public hospital. All rest home and hospital beds are certified for dual purpose. Bupa's overall vision and values are displayed in a visible location. All staff are made aware of the vision and values during their induction to the service. There is an overall Bupa business plan and risk management plan. There are documented quality/health and safety goals that are reviewed monthly and signed off when achieved. The care home manager was appointed in Nov 2016. She has over 40 years of nursing experience and holds a post graduate diploma in rehabilitation. She is supported by a clinical manager/RN and two-unit coordinators/RNs. The clinical manager was appointed in Dec 2016 and holds a post graduate certificate

		in gerontology. The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.
Standard 1.2.2: Service Management 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.	FA	In the absence of the care home manager, the administrative staff and the clinical manager/RN with support from the operations manager are in charge. For extended absences, a Bupa relieving care home manager is rostered.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	A quality and risk management programme is in place. Interviews with three managers (care home manager, clinical manager, operations manager) and twenty-two staff (eighteen care staff, one chef, one maintenance staff, one household manager, one laundry) confirmed their understanding of the quality and risk management systems. 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 - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures include reference to interRAI for an aged care service and meet current health and safety legislative requirements. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Data collected (e.g., falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are collected and evaluated with results communicated in the quality meetings. Data collection and analysis is undergoing a transition to a new electronic system (Riskman), effective June 2017. Quality outcomes are displayed for staff to review in the staff room. Corrective actions are implemented where data exceeds acceptable levels. An internal audit programme is in place. In addition to scheduled monthly internal audits, an annual facility health check is conducted by an external Bupa representative. Areas of non-compliance include the initiation of a corrective action plan with sign-off by the care home manager when implemented. Corrective actions from the last health check identified their implementation. Internal audits are repeated with greater frequency where results reflect required improvements until acceptable thresholds are met.

		Annual resident satisfaction surveys are conducted. The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. The care home manager is the health and safety officer. The health and safety team meets two- monthly. Staff undergo annual health and safety training which begins during their orientation. All staff are provided with information about their responsibility under the Health Safety at Work Act 2015. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. Bupa facilities have been awarded ACC work safety management practice at a tertiary level (expiry 5 July 2018). Strategies are implemented to reduce the number of falls. This includes (but is not limited to) ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding.
Standard 1.2.4: Adverse Event Reporting 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.	FA	There is an accident and incident reporting policy. Adverse events are investigated by the registered nurse at the time of the event and by the clinical manager each month, evidenced in all fifteen accident/incident forms reviewed. Adverse events are linked to the quality and risk management programme. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations. Discussion with the care home manager and clinical manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	There are human resource management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. A register of current practising certificates is maintained. Nine staff files reviewed (three caregivers, three RNs, one cleaner, one activities assistant and one kitchen assistant) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements and job descriptions. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Missing was consistent evidence that staff had completed their orientation. Education includes in-services, competency assessments and impromptu 'toolbox' talks. Education topics cover subjects relevant to young people with physical disabilities. Attendance rates are low. Performance appraisals are behind schedule. Kitchen staff have completed their food safety training on-site. Chemical safety training is included in staff

		orientation and as a regular in-service topic. Eight of fifteen RNs have completed their interRAI training. RNs have also completed first aid/CPR training and provide cover onsite 24/7. Missing was evidence of activities staff who take residents on outings holding current first aid certificates.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A staff rationale and skill mix policy is in place. Staffing on each wing is determined by resident acuity. The care home manager and the clinical manager are RNs who are employed on a full-time basis (Monday – Friday). They are supported by two-unit coordinators/RNs (Monday – Friday) Sufficient staff are rostered on to manage the care requirements of the residents. The facility covers three floors with an elevator placed in an accessible location. All beds are certified for dual-purpose. Residents are placed in the most appropriate room, which is based on bed availability, the resident's comorbidities (e.g., high falls risk, disease complications), RN input required, and the resident's language spoken. The ground floor (Orion) is predominately rest home level residents (fifteen rest home and five hospital). It is staffed with two caregivers on the AM and PM shifts (one long and one short) and one caregiver on the night shift. Oversight is provided by a unit coordinator/RN (who is based on the second level). The staff RN on the second level provides support when the unit coordinator is not available. The first floor includes two wings and is predominately hospital level of care with twelve hospital and eight rest home (Pegasus wing) and sixteen hospital and five rest home (Phoenix wing). A unit coordinator/RN provides oversight Mon – Friday and is supported seven days a week by two RNs from 7am – 7pm and one RN 7pm to 7am. Six caregivers are rostered on the first level during the am and pm shifts (four long and two short) and two caregivers are rostered on the night shift (long shifts only). An extra caregiver staff, provided by NASC, is staffed on the am shift for one YPD resident. The second floor (Gemini wing) has twelve hospital and ten rest home level residents. It is staff with a unit coordinator/RN (Mon-Fri), and one RN 24/7. Three caregivers cover the am shift (two long and one short), two on the pm shift (long) and one on the night shift (long). Four activities staff are rostered five days a week, which also accounts for the day care programme that includes four residents per day. Separate cleaning and laundry staff are rostered. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management	FA	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files

Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.		are protected from unauthorised access. Informed consent to display photographs is obtained from residents/family/whanau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregiver or RN. Resident files are held separately from the short-term care plans (link 1.3.3.4).
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are policies and procedures to safely guide service provision and entry to services, including a comprehensive admission policy. Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has a well-developed information pack available for residents/families/whānau at entry. The admission agreement reviewed aligns with the service's contracts. Ten admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions (two were reviewed). All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge, was well documented in progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication chart and any pharmacy errors recorded and fed back to the supplying pharmacy. The service uses an electronic medication management system and robotic packs. Registered nurses, enrolled nurse and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Other competencies completed by RNs include insulin administration and syringe driver. There is one resident self-medicating and all competencies and documentation were up-to-date. The unit coordinator advised that YPD residents are supported to self-medicate where able. Three charts were reviewed for residents receiving insulin. All included records of BSLs and administered insulin (as per GP instructions). The medication fridges on each floor had temperatures recorded daily and these were within acceptable

		ranges. Twenty medication charts were reviewed across three floors. Photo identification and allergy status were documented; however, shortfalls were identified in Orion wing. Fifteen of twenty electronic medication charts had been reviewed by the GP at least three-monthly. Five resident charts reviewed of residents on PRN and regular controlled drugs aligned with CD register and included reason for administration and effectiveness. Documentation around phoned verbal orders did not align with good practice.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service employs one head cook (Monday-Friday) and one weekend cook. There are four kitchenhands in total. All kitchen staff have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked onsite. Meals are delivered to the wings in bain-maries. On the day of audit, meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and recorded daily. These were all within safe limits. A food control plan has been developed. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly (or earlier) as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. The national Bupa menus have been audited and approved by an external dietitian.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency if entry were declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a	FA	The facility has embedded the interRAI assessment protocols within its current documentation. Bupa assessment booklets on admission and care plan templates were comprehensively completed in the majority of resident files reviewed (link 1.3.5.2). InterRAI assessments including assessment summary, MDS comments and client summary reports were evident in printed format in all files. All files reviewed identified that risk assessments have been completed on admission and reviewed at least six-monthly as

timely manner.		part of the evaluation and multi-disciplinary review process. Additional assessments for management of behaviour, pain, wound care and restraint were completed according to need. For the resident files reviewed, formal assessments and risk assessments were in place and reflected into care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	Care plans reviewed overall were individualised and demonstrated service integration and input from allied health and specialists (link 1.3.3.4). Overall long-term care plans sampled identified interventions to support current medical needs and links to specialists involved in resident care. Of the 10 resident files reviewed, three hospital and two rest home care plans (including the respite) did not include all interventions to support all current assessed needs. Residents and family members interviewed confirm they are involved in the development and review of care plans. Short-term care plans were in use for changes in health status (link 1.3.3.4).
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Overall, the care summary and LTCPs reviewed included interventions that reflected the resident's current needs (link 1.3.5.2). When a residents' condition changes the RN initiates a GP visit or specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Registered nurses were regularly involved in resident daily care and ongoing assessments as identified in the progress notes. Continence products are available and resident files include bowel management, and continence products identified for day use, night use, and other management (link 1.3.5.2). Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies. Wound care folders were reviewed in all areas. A sample of wound documentation was reviewed including a review of the four current pressure injuries (three facility-acquired grade 2, and one non-facility acquired grade 2). Wound assessment and management plans provide a record of wound progress and these are being documented as per policy. Monitoring charts were well utilised at David Lange and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required.
Standard 1.3.7: Planned	FA	Activities are provided across 7 days with activities held during the morning and afternoons. There is a

Activities 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.		programme per floor with one-on-one activities also provided. There is one activities coordinator (40 hrs weekly- trained DT) and three activities assistants, (one employed 20 hours, one 25 hours and one 35 hours weekly). All four have attended BUPA activities study days. The activity team meet fortnightly to develop the programme. The activities team have been trained by the physiotherapist, and supervises residents' daily exercises and walks, when the physiotherapist is not present. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. The activities co-ordinator has developed a TV and computer system that is used to display all up come events and captures past events like photos of the planting session of the front garden. This allows information to be constantly available and especially useful for informing families out of normal office hours. It also allows them to display staff notices, upcoming event etc. In 2017, David Lange had a quality goal around 'the enhancement of the activities programme'. This was in response to a theme of discontentment throughout resident surveys, residents' advocacy meetings and resident and family meetings. With the appointment of a qualified DT as the-coordinator and better engagement of the team there has been a marked improvement. This improvement is evident in survey results, interviews and meeting minutes. The team of activity staff are multi-cultured and provide activities that meet the cultural needs and requests of residents. The Bupa activities programme template is designed for high end and low end cognitive functions and caters for individual needs. This has been personalised for David Lange to also specifically meet the cultural needs of residents. Church groups visit weekly and cultural theme days are regularly held. There are van outings daily. The van also picks up day care residents in the morning (up to 5 a day). Events such as birthdays, Easter, Mother's Day are celebrated. All residents are encouraged to attend community events/groups and encouragement is given to YPD residents. Three of the four YPD residents currently attend outdoor interests. Bupa has set activities on the programme calendar with the flexibility to add site-specific activities, entertainers and outings. One-on-one time is spent with residents who are unable to or choose not to join in the group activities. One resident loves art, so art is completed with the resident one-on-one. Residents are encouraged to maintain links with the community with visits to clubs and other community groups. There are regular entertainers to the home and residents go on regular outings and drives. The service had a wheelchair hoist van. The family/resident completes a 'Map of Life' on admission, which includes previous hobbies, community links, family, and interests. The individual activity plan is incorporated as part of the long-term care plan under the sections 'socialising and activities' and 'my day, my way'. Resident files reviewed identified that the individual activity plan is reviewed at least six

		monthly. Residents/family have the opportunity to provide feedback on the activity programme through resident meetings (with an advocate) and satisfaction surveys. Residents and family interviewed stated the activity programme was varied and there were lots to choose from. There are up to five-day care residents daily. Interviews with residents, relatives and staff confirmed they fit in well with other residents and enjoy the activities together.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Written evaluations reviewed described the resident's progress against the residents identified goals. InterRAI assessments have been completed in conjunction with the six-monthly reviews. Overall short-term care plans for short-term needs were implemented but not always evaluated or linked to the LTCP (link 1.3.3.4). There was documented evidence where long-term care plans had been updated where health conditions had changed (link 1.3.5.2). The multidisciplinary review (MDR) involves the RN, GP, physiotherapist, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. Residents interviewed confirmed involvement in the MDR meetings. There is at least a one or three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident's condition had changed, and the resident was reassessed for a higher or different level of care. Discussion with the unit coordinators and RNs identified that the service has access to a wide range of support either through the GP, Bupa specialists and allied services. Files reviewed included referral to a number of services including (but not limited to) dietitian, wound care specialist, speech language therapist, and occupational therapist. Two files were reviewed of residents that were referred to a speech language therapist (SLT). Records were timely and SLT instructions included in the resident file but not always reflected in the care plan (link 1.3.3.4).
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected	FA	There are policies and procedures on waste management. Management of waste and hazardous substances is covered during orientation of new staff and is included as part of the annual training plan. There are documented policies, procedures and an emergency plan to respond to significant waste or hazardous substance management. Material safety datasheets are available in the laundry and the sluices on each floor. There is a secure

from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		sluice on each floor with a sanitiser. There is a sharps container in the treatment rooms on each floor. Gloves, aprons and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested and tagged and calibrated. A maintenance person is employed full-time. A reactive and preventative maintenance programme is being implemented. There are contractors for essential service available 24/7. The corridors are wide with handrails and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. There is a lift between floors that is large enough for stretcher bed. There are sufficient seating areas throughout the facility. Caregivers interviewed confirmed there is adequate equipment to carry out the cares according to the resident needs as identified in the care plans. The equipment needs of bariatric residents and also YPD residents. Occupational therapist assessments have been completed for equipment needs where needed. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. The service has embarked on a garden beautification project which involved resident participation and has enhanced the outside of the front of our building immensely. They continue to develop the back garden where they grow the herbs for use in the kitchen.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	There are rooms with full ensuites, rooms with shared ensuites and rooms without ensuites. There are sufficient numbers of resident communal toilets and showers in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets and showers are well signed and identifiable and include large vacant/in-use signs.
Standard 1.4.4: Personal Space/Bed Areas	FA	The resident rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		the residents. Caregivers interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms are personalised. Double rooms include curtains for privacy.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a large lounge and dining room on each level. The dining rooms and lounges are spacious. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they are able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There is a laundry manual and cleaning procedures are available. All laundry is transferred off-site to another Bupa facility for laundering. David Lange monitors the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area where dirty laundry is transferred, and clean laundry is collected. Staff have attended infection control education and there is appropriate protective clothing available. Manufacturer's data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility. The service has implemented a project and looked at the way they use and supply linen to the residents. This has seen them centralize the linen in one point with a trolley available on each floor with the linen supplies being restocked 3x a day. This has meant that the linen is now more visible and available. They are currently gathering information around stock control and usage from their centralised laundry to support it effectiveness.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Fire drills are scheduled every six months. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times at the facility. Activities staff who take residents on outings do not hold current first

		aid and CPR certificates (link 1.2.7.5). There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. Security systems are in place to ensure residents are safe
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.
Standard 3.1: Infection control management 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.	FA	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 unit coordinator (RN) and she is responsible for infection control across the facility. The committee and the Bupa governing body is responsible for the development of the infection control programme and its review. There is an organisational care home IC meeting that last met August 2017. They review the overall Bupa IC programme. The facility infection control committee consists of a cross-section of staff and there is external input as required from general practitioners, and Bupa quality & risk team. There was a gastric outbreak reported February 2017 that affected 10 residents and six staff. A case log and outbreaks meetings were held during this time. A respiratory outbreak was reported (via section 31) June 2017 that affected 15 residents. Toolbox talks were provided to staff following the outbreaks around review of processes and from learnings gained during the outbreaks.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at David Lange. The infection control (IC) coordinator has maintained best practice by attending an external infection control & prevention training day. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.

Standard 3.3: Policies and procedures 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.	FA	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.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	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. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice and group benchmarking. Infection control training is regularly held as part of the annual training schedule. IC competencies and toolbox talks are also held.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There were five IC goals identified in 2017 that have recently been evaluated. There is close liaison with the general practitioners that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where trends are identified.
Standard 2.1.1: Restraint	FA	Policies and procedures include definitions of restraint and enabler that are congruent with the definition

minimisation Services demonstrate that the use of restraint is actively minimised.		in NZS 8134.0. Restraint is discussed as part of staff meetings and in separate restraint meetings. Documented systems are in place to ensure the use of restraint is actively minimized. There were two hospital level residents using restraints and nine hospital level residents using enablers at the time of the audit. A registered nurse is the restraint coordinator. He understands strategies around restraint minimisation and assists with staff education around restraint minimisation. Staff interviews evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Education and competencies on restraint minimisation are scheduled annually (link 1.2.7.5). Two residents' files reviewed where an enabler was being used (bedrails) reflected an assessment and consent process had been completed with regular reviews. Residents using an enabler are monitored for safety (link 2.2.3.4).
Standard 2.2.1: Restraint approval and processes 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.	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (staff RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the RN in partnership with the GP, resident and their family/whānau. Oversight is provided by the restraint coordinator. Restraint assessments are based on information in the care plan (link 1.3.5.2); resident/family discussions and observations. On-going consultation with the resident and family/whānau are evident. Both files for the two residents using restraints were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint	PA Low	Procedures around monitoring and observation of restraint use are documented in policy. Approved

Use Services use restraint safely		restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint was linked to the resident's restraint care plan in one of two files reviewed (link 1.3.5.2). An internal restraint audit, conducted annually, monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Staff were not completing the monitoring forms accurately.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are scheduled three-monthly and frequently occur with greater frequency (e.g. two monthly). Restraint use is discussed in a range of meetings (restraint meetings, staff meetings, RN meetings) confirmed in the meeting minutes.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The Bupa restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme.

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)
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Staff are provided with an orientation programme that is specific to their role and responsibilities. Interviews with staff confirmed that the orientation programme is comprehensive. Missing in the staff files reviewed was evidence that staff had completed their orientation programme.	Six of thirteen staff files of staff who had been employed since the last audit were missing evidence that they had completed their orientation programme. (Note: sample size was expanded).	Ensure evidence is retained to confirm that newly employed staff have completed their orientation programme. 90 days

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.	PA Low	An education and training programme is in place that includes monthly in-service training and annual competency assessments. Training topics are extensive and cover both aged care and young persons with a disability. Education records reflect low attendance at in-service sessions. Performance appraisals are behind schedule. RNs have current CPR certificates but activities staff who take residents on outing are in need of first aid certificates.	i) Four of ten caregivers have attended less than eight hours annually of education. Attendance rates are often low (less than 50% attendance). This has been identified as an issue by the management team and a corrective action is being implemented for the 2018 calendar year. ii) Six of seven staff files reviewed of staff who have been employed for over one year were missing evidence of an annual performance appraisal. iii) Activities staff who accompany residents on outings did not hold current first aid/CPR certificates.	i) Ensure all care staff attend a minimum of eight hours annually of professional development as per the aged residential care contract agreement. ii) Ensure staff undergo annual performance appraisals in line with Bupa policy. iii) Ensure there is a minimum of one staff trained in CPR/first aid to accompany residents on outings. 90 days
Criterion 1.3.12.6	PA	The GP visits two days a week and is on-call 24/7.	A review of 20 medication charts across three floors identified the following shortfalls; (i) five medication	(i)Ensure overdue 3-

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	Moderate	Twenty medication charts were reviewed across three floors. Photo identification and allergy status were documented; however, shortfalls were identified in Orion wing. Fifteen of twenty electronic medication charts had been reviewed by the GP at least three-monthly. Five resident charts reviewed of residents on PRN and regular controlled drugs aligned with CD register and included reason for administration and effectiveness. Documentation around phoned verbal orders did not align with good practice.	charts were overdue for three-monthly GP reviews. (ii) Three of five electronic charts in Orion wing did not have photo ID. One of five did not have allergies documented. (iii) There were eight phone order medication charts across the three medication folders. While all eight had been signed by two staff (one being an RN), the GP had not followed up and signed the form or updated the electronic medication chart. (noting, the GP on the day of audit signed four of the eight charts and updated the electronic medication chart)	monthly reviews are followed up and completed by GPs; (ii) Ensure electronic records include photo ID and allergy status; (iii) Ensure the process around phone-orders is followed to meet policy and guidelines 30 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Moderate	Care staff interviewed (across all services) could describe a verbal and written handover at the beginning of each duty that maintains a continuity of service delivery. Caregivers complete daily task lists and RNs complete written progress notes. Allied health interventions were overall well documented and integrated	(1) Short-term care plans (STCPs) are completed for acute changes in health status. Currently current STCPs are stored in a separate folder from the residents file, therefore when reviewing resident files, it was unclear if a resident had a current STCP in place. STCPs in place for the Orion wing (ground floor) are currently stored on the top floor, so are not accessible for the care staff undertaking cares to residents in Orion wing. A review of the STCP folders on floor one and two identified the following shortfalls; (i) Orion folder- seven STCPs were not personalised or evaluated; 14 STCPs within the same folder (completed previous to November 2017) were not	(1) Ensure STCPs are integrated in resident files; Ensure STCPs are personalised and evaluated; (2) Ensure allied health instructions are updated

		into six of 10 care plans reviewed. There is a number of specialists involved with the service and residents'. There is documented support and input from a clinical nurse specialist. There were shortfalls identified around STCP documentation and the storage of STCPs does not promote continuity of service delivery.	evaluated and therefore it was unclear if they remain current or were obsolete. (ii) On level one (Phoenix and Pegasus wings), there were three STCPs for current pressure injuries. The generic STCP template was not personalised and therefore some of the interventions were irrelevant for the actual type and location of pressure injury and where the pressure injury was located was not documented (i.e.: sacral). (iii) In Gemini wing (level two), there was one STCP not personalised and therefore it was unclear what the STCP was for. (2) Five of ten care plans reviewed did not include all allied health required cares documented as interventions; (i) one hospital resident had swallowing guidelines from the SLT in the care summary but not in the LTCP. (ii) one hospital care plan documented choking risks but not signs of aspiration or link to the SLT current assessment/interventions; (iii) one rest home and one hospital care plan did not have the interventions updated from the recent dietitian assessment/review (iv) One hospital resident with a CVA that had physiotherapy instructions around the use of a wrist brace and exercise to prevent further contractures did not have this documented in the care plan.	as interventions in care plans. 60 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Ten resident files were reviewed for this audit. The YPD file reviewed was resident-centred, including interventions to support ADLs and medical needs. The care plan also identified specific goals around activities and community involvement. Resident-centred goals	The following shortfalls were identified in the files reviewed. (i) The rest home respite care plan lacked interventions to support all current needs as identified in the initial assessment (i.e., continence management). (ii) The care plan for one hospital resident did not reflect the use of an oxygen concentrator and management of risks. (iii). One hospital resident with CVA had the following gaps in care plans; a) Care summary states resident incontinent but care plan did not include any management plan, b) restraint not updated in care plan	Ensure care plans are updated to include interventions to support all current needs.

		were reviewed at the multi-disciplinary review (MDR) meetings with the resident. Of the 10 resident files reviewed, three hospital and two rest home care plans (including the respite) did not include all interventions to support all current assessed needs.	to align with the restraint assessment, c) nutritional profile updated to reflect resident on pureed diet, this was not updated in the care plan; (iv) One rest home resident did not have interventions to support care of ileostomy and skin integrity in the care summary or LTCP; (v) one hospital residents cultural assessment states " no male caregivers", this was not included in the care summary or LTCP. The same resident has a bedrail (enabler) that was not included in the care plan. Interviews with caregivers and registered nurses supported knowledge around current care and support required for these three residents and therefore the risk has been identified as low.	90 days
Criterion 2.2.3.4 Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of	PA Low	Both residents using restraint (one chair brief and one lap belt) were assessed as requiring two hourly monitoring. Monitoring forms only indicated when the restraint had been initiated and when it had been removed, which frequently exceeded two hourly.	Restraint monitoring charts for both residents using restraint were lacking adequate detail to reflect two hourly monitoring.	Ensure each episode of restraint use is monitored in sufficient detail to reflect regular checks as indicated on the restraint assessment form. 90 days

the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.				

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
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	CI	The service has taken onboard feedback on menu and food choices and implemented a project around meeting the cultural needs of residents. As a result of the project, each meal includes choices on the menu included specific cultural dishes that meet the needs of the large number of Indian and island residents.	In response to continual complaints about access to choice around food the service has introduced individual daily menus which provide choice and evidence of those choices. The service provides access to a variety of food choices related to a cultural diversity and these choices are now available in a much more foldable way. There are two meus daily (the 2nd menu is multi-national). This has been discussed and reviewed by a dietitian. There is a daily Indian menu, a 2x weekly island menu and alternative menu. Residents and families interviewed were very happy with the meals provided especially around the cultural choices. Satisfaction surveys show an improvement in satisfaction.

End of the report.