Bupa Care Services NZ Limited - Stokeswood Rest Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Stokeswood Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 12 March 2018 End date: 13 March 2018
Proposed changes to current services (if any): None	
Total beds occupied across all premises included in the audit on the first day of the audit: 82	

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

Bupa Stokeswood is part of the Bupa group. The service is certified to provide rest home, hospital (geriatric and medical) and dementia care for up to 87 residents. On the day of audit there were 82 residents.
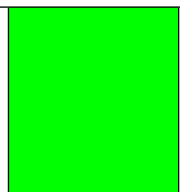
This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and general practitioner.

Stokeswood is managed by a care home manager (registered nurse) who has been in the role for 18 months. The manager is also supported by a clinical manager, unit coordinators and Bupa operations manager. Family and residents interviewed spoke positively about the care and support provided at Bupa Stokeswood.

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 Stokeswood and has been embedded in practice. Quality initiatives are implemented, which provide evidence of improved services for residents.
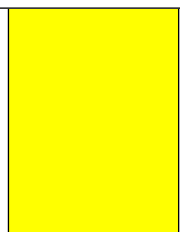
There are improvements required by the service around training, care plan interventions, medication documentation and aspects of the external environment.

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.

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

Organisational management

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

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

is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. There is an in-service training calendar in place. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		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.

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

All food and baking are 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.		Some standards applicable to this service partially attained and of low risk.

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. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. 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.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. At the time of audit, there were two residents with three restraints and three residents with four enablers. Assessments and consents were completed for the enablers. The service has an approval process that is applicable to the service. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. Restraint use is reviewed through the three-monthly evaluation, monthly restraint meetings and six-monthly multidisciplinary meeting, which includes family/whānau input.

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. 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	46	0	3	1	0	0
Criteria	0	97	0	3	1	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 (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training, last completed in February 2018. Interviews with seven caregivers (across all three areas), two registered nurses (RN), two-unit coordinators and three activity coordinators, reflected their understanding of the key principles of the Code.
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 informed consent.	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, two-unit coordinators and two registered nurses (RNs) confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. 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	Information on advocacy support services is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support services. Staff receive education and training on the role of advocacy services, last occurred in February 2018.
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 may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident/family meetings are held at least two monthly and a resident advocate attends the meeting. Quarterly newsletters are provided to residents and relatives.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. Fifteen complaints received since the last audit were reviewed with evidence of appropriate follow-up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints. Feedback is provided to staff and toolbox talks were completed where required. An additional complaint made recently through the Health & Disability Commissioner (HDC) in 2018 has been investigated and followed up. The Bupa clinical service improvement (CSI) team responded to the HDC letter in March 2018.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and RNs discuss aspects of the Code with residents and their family on admission.

Consumers are informed of their rights.		Discussions relating to the Code are held during the bi-monthly resident/family meetings. All eleven residents (seven rest home and four hospital) and eight relatives (three rest home, two hospital and three dementia) interviewed, reported that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.
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	Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. The 2017 satisfaction survey identified 95% of residents were happy with privacy. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training, last completed in February 2018 (link 1.2.7.5). Residents admitted to the dementia community (Rotary unit) are assisted and supported to maintain as much independence as possible.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There are two residents whom identify as Māori living at the facility. A file review included a Māori health plan and identified involvement in specific Māori community events as requested by the resident. Māori consultation is available through the documented Iwi links and local Māori ministers. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.
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 identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. The 2017 satisfaction survey identified 67% outcome for cultural/spiritual needs being met. Quarterly newsletters are provided to residents and relatives. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

| 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. Code of conduct training is also provided through the in-service training programme. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
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 24 hours a day, seven days a week. A general practitioner (GP) visits the facility two days a week and as needed. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. Physiotherapy services are provided on-site, two to three hours per week. A podiatrist is on-site every six-weeks. The service has links with the local community and encourages residents to remain independent. All quality data is imputed in Riskman and benchmarked reports are provided. Stokeswood completes an analysis of the graphs and a corrective action plan is routinely developed by the service where shortfalls are identified.

Once a week management and unit coordinators, attend a clinical review meeting to discuss issues of the week so all RNs are aware for the weekend and following week. There is one RN assigned to chair a Falls Focus group. From 14 February 2018, a monthly case review/mentorship programme for RNs/EN commenced, which is facilitated by the nurse practitioner, until November 2018 at Stokeswood. RN/EN meetings are held monthly and education topics are discussed during these sessions. The RN educator runs education programmes for the RNs. Syringe driver training has been completed and other topics (also refer 1.2.7.5). |
| Standard 1.1.9: Communication

Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen accident/incident forms reviewed across the three service areas (four rest home, seven hospital and four dementia) from January and February 2018, identified that family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.

An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. Non-subsidised residents are advised in writing of their eligibility and the process to become |

		a subsidised resident should they wish to do so.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Bupa Stokeswood Rest Home and Hospital is a Bupa residential care facility. Stokeswood provides rest home, hospital and dementia level care for up to 87 residents. At the time of the audit there were 82 residents; 41 rest home residents including two residents on respite and one resident on a combined contract (DHB and ACC) and 21 hospital residents. There were 20 residents in the 20-bed dementia care community unit. A vision, mission statement and objectives are in place. Annual quality/health and safety goals for the facility have been determined and are regularly reviewed by the care home manager. A quarterly report is prepared by the care home manager and provided to the Bupa clinical service improvement team on the progress and actions that have been taken to achieve the Stokeswood quality goals. Stokeswood has identified three goals in 2018, one national goal (health and safety) and two facility-specific (reducing falls and preventing pressure injuries). Progress to meeting these goals is reviewed at every quality meeting. The 2017 goals have been progress reported quarterly and annually. The evaluation identifies that all 2017 goals were met. The service is managed by a care home manager who is a RN. The care home manager has been in the role for six months and has been at Bupa since 2011 and has managed a number of Bupa facilities. She is supported by an experienced clinical manager who has been in the role since December 2017, having previously worked as a clinical manager at another Bupa facility for nine months. The management team is supported by three-unit coordinators and a regional operations manager. Care home managers and clinical managers attend annual forums and regional forums six monthly. The care home manager has maintained at least eight hours annually of professional development activities related to managing a rest home/hospital.
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	A clinical manager who is employed full time, supports the care home manager and steps in when the care home manager is absent. There is a regional operations manager, who visits regularly and supports both managers.

| 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 well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule.

Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed. Riskman has been implemented by Bupa, which is an electronic data collecting system. All incidents, complaints, infections, pressure injuries, falls, category one incidents are completed on the online system. Reports are automated and further analysis is completed of those reports. Stokeswood reports, analysis and consequent corrective actions were sighted. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. Quality and risk data is shared with staff via meetings and posting results in the staffroom. An annual satisfaction survey is completed, and 2017 results demonstrated a 93% positive outcome. Corrective actions were established in areas identified as below the national average.

The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There is a health and safety officer (caregiver) who is supported by health and safety representatives. The health and safety team meet bi-monthly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. The hazard register is reviewed regularly. Bupa belongs to the ACC partnership programme and has attained their tertiary level (expiry 31 March 2018). Strategies are implemented to reduce the number of falls. This includes, (but is not limited to), a falls committee has been established in October 2017 to review all falls, ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding. |
| Standard 1.2.4: Adverse Event Reporting

All adverse, unplanned, or untoward events are | FA | Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. All incidents are coded in severity on Riskman (severity 1-4) with 4 being the most severe. All resident incidents logged with a severity of 3 or 4 are |

systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		automatically escalated to the Bupa CSI team immediately and the regional operations manager. Actions are then followed-up and managed. Fifteen accident/incident forms were reviewed across the three service areas. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Incidents are benchmarked and analysed for trends. The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been six section 31 notifications made since the last audit. One unstageable pressure injury in November 2016, four residents absconding in October 2016, March 2017, September 2017 and November 2017 and one communication outage in November 2016. All included implemented corrective actions.
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 resources policies in place, including recruitment, selection, orientation and staff training and development. Eleven staff files (one clinical manager, two-unit coordinators, two RNs, four caregivers, one diversional therapist and one kitchen manager) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g., RN, support staff) and includes documented competencies. New staff are buddied for a period of time (e.g., caregivers two weeks, RN four weeks), and during this period they do not carry a clinical load. The caregivers, when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. There are fourteen caregivers that work in the dementia community/unit and nine have completed the required dementia standards, five caregivers are in process of completing their dementia standards. There is an annual education and training schedule in place. The service provides regular in-service education and sessions have been provided that address all required areas. However, attendance numbers at trainings have been low. Of the ten RNs at Stokeswood, six have completed interRAI training and one RN is in training. A competency programme is in place with different requirements according to work type (e.g., support work, registered nurse, and cleaner). Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). RN competencies include assessment tools, BSLs/insulin administration, CD administration, moving & handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, CPR and T34 syringe driver.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The staffing levels meet contractual requirements. The clinical manager is on-call after hours with other RNs. The care home manager and clinical manager are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers' support the unit coordinators and RNs. Staff interviewed advised that there are sufficient staff on duty at all times. In the Rotary dementia community, there were 20 of 20 residents. On the morning shift there is one-unit coordinator/RN on duty for three days Tuesday, Wednesday and Friday, who is supported by three caregivers. On the afternoon shift, there is one RN (across dementia and rest home units) and three caregivers and on the night shift, there is one RN (across dementia and rest home units) and two caregivers. In the Hospital unit, there were 21 of 24 hospital residents. On the morning shift, there is one-unit coordinator/RN or RN on duty from Monday to Sunday, who is supported by four caregivers. On the afternoon shift there is one RN and four caregivers, and on the night shift there is one RN and one caregiver. In the rest home unit, (across Glen and Slaven units) there were 41 of 43 rest home residents. On the morning shift there is one-unit coordinator/EN on duty from Monday to Friday, who is supported by three caregivers. On the afternoon shift there is one RN (across dementia and rest home units) and three caregivers and on the night shift there is one RN (across dementia and rest home units) and two caregivers. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation.
Standard 1.3.1: Entry To Services	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.

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.		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 sighted in the resident records of a resident with a previous acute hospital admission. 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. Stock medication including oxygen was being monitored weekly. The medication fridges in each unit had temperatures recorded daily and these were within acceptable ranges. Two rest home residents were self-medicating and competencies were completed. One hospital chart was reviewed for a resident receiving insulin. The chart included records of BSLs and administered insulin (as per GP instructions). One rest home resident (not on insulin) had a BSL of 24mmol and this was not reported or followed up by staff. All controlled drugs included two staff signatures, however management of controlled drugs in the dementia community/unit did not fully meet legislative requirements and medication guideline. A shortfall was also identified around the medication management of a respite resident in the rest home. Twenty medication charts were reviewed across the three units. Photo identification and allergy status were documented. There were indications for use documented for PRN medication.

| 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 full-time kitchen manager and one-part time cook. There are nine kitchenhands in total. All kitchen staff have current food safety certificates. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. 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 verified 22 September 2017. 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.

There is a small kitchen off the dementia community/unit dining area. There are adequate snacks available for residents 24/7. |
|---|---|---|
| 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 timely manner. | 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 long-term files. All files reviewed identified that risk assessments have been completed on admission and reviewed at least six-monthly as 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. Overall long-term care plans sampled identified interventions to support current medical needs. Overall, care plans had been updated for changes in health status, but obsolete interventions were not always removed or signed out. 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. Three files (dementia level care) reviewed included specific dementia care plans that includes behaviours and de-escalation techniques.
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 was overall good. 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. 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 three areas. A sample of wound documentation was reviewed including a review of the three current pressure injuries within the facility (two hospital, both facility acquired – one unstageable R) outer ankle, and a grade 2 sacral, and one recently healed grade 1 heel) in the rest home. Wound assessment and management plans provide a record of wound progress and these are being documented as per policy. Wound tracing and photos were completed for the unstageable pressure injury and involvement of a wound care nurse specialist was identified in the records. Monitoring charts were well utilised at Stokeswood 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. Two files were reviewed of residents that had section 31s completed due to absconding (one dementia and one rest home). Review of care plans, progress notes and incident forms identified that the risks and follow-up corrective action plans (CAP) had been identified and well managed. Care plans were reflected of increasing monitoring and risks. Half hourly monitoring charts were implemented.

Standard 1.3.7: Planned Activities	FA	Activities are provided across six days with activities held during the morning and afternoons. There is a programme in each area with one-on-one activities also provided.
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.		The service developed a quality action plan as a result of satisfaction survey feedback in 2017 around improving the overall activities programme in all three areas. As part of the corrective action (but not limited to), a dedicated activity person has been assigned in each area and the outcome of a number of actions/improvements implemented identified a more robust programme has been implemented, a male resident has also benefited from the community men's shed group and resident/relative meetings have commenced in all three areas.
		There is one trained diversional therapist (30 hrs weekly - in rest home) and two activity assistants employed 30 hours across the hospital and dementia communities and one activities assistant who works 10-12 hours per week in the dementia community and fills in when one activities assistant is on leave. The two activity assistants that work across the dementia unit have completed the dementia standards. The activity team meet monthly to develop the programme.
		On the day of audit, residents in all areas were observed being actively involved with a variety of activities.
		Group activities are voluntary and developed by the activities staff. Residents were able to participate in a range of activities that were appropriate to their cognitive and physical capabilities. The service has a mobility van that is used for resident outings. The group activity plans were displayed on noticeboards around the facility. There is one programme for the rest home and hospital and residents attend which activity they wish to attend. A separate programme is provided in the dementia community/unit and dementia residents often join (under supervision) concerts and events with the other residents. All residents who do not participate regularly in the group activities are visited by a member of the activity staff with records kept ensuring all such residents are included.
		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 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. Files reviewed in the dementia community included activity plans across 24/7 as part of the LTCP.
		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.

Standard 1.3.8: Evaluation

Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Written evaluations reviewed, described the residents' 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. 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, PG team from the HVDHB and older person's rehabilitation. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety datasheets were readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. A chemical spills kit is available. |
| Standard 1.4.2: Facility Specifications

Consumers are provided with an | PA Low | The building has a current building warrant of fitness that expires on 30 June 2018. There is a full-time property manager who is available on call for facility matters. Planned and reactive maintenance systems are in place and maintenance requests are generated through maintenance request books. All electrical equipment has been tested and tagged. Clinical equipment has had functional |

appropriate, accessible physical environment and facilities that are fit for their purpose.		checks/calibration annually. Hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7.
		Corridors are wide enough in all areas to allow residents to pass each other safely. Handrails are available in hallways and warning signs are in place for change in floor services. There is access to all communal areas and outdoor areas. There is outdoor seating and shade available in all areas. There is a designated smoking area for residents who smoke. There is a large outdoor area off the dementia community/unit that extends around the dementia community/unit with identified hazards. There is a plan in place to further landscape this secure outdoor area and remove uneven services and potential hazards.
		The caregivers and registered nurses (interviewed) state they have all the equipment required to provide the care documented in the care plans. The following equipment is available (but not limited to): electric beds, ultra-low beds, sensor mats, standing and lifting hoists, mobility aids and wheel-on weigh scales.
		Since the previous audit the service has been completing a refurbishment of bedrooms in the rest home as they become vacant. There are also plans to refurbish the Straven lounge in the rest home. Hanging baskets & beautifying of the driveway and throughout the grounds has been created by their gardening contactor. The gardening contractor has also built a raised herb garden for the kitchen to use.
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 | Visual inspection evidences toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All bedrooms in the hospital have a single ensuite, rest home - single toilet and shared shower facilities and dementia community/unit shared facilities. Communal bathrooms are large enough for mobility equipment. There are sufficient showers and toilets for the residents in all units. There are communal toilets located near the lounge/dining rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant. |
| Standard 1.4.4: Personal Space/Bed Areas

Consumers are provided with adequate personal space/bed areas appropriate to the | FA | There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms in all areas. The doors are wide enough for ambulance trolley access. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.

Coloured doors are used in the dementia community/unit to assist residents with finding key rooms such as bathrooms. Doors are personalised with memorabilia to assist residents to locate their rooms. |

consumer group and setting.		
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	Communal areas within the facility include an open plan lounge and dining area in each of the three units. There are smaller lounges and a family room within the facility. The communal areas are easily accessible for residents.
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 are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry has a dirty to clean work flow with two doors - entrance and exit. There are dedicated laundry and housekeeping staff. All linen and personal clothing is laundered on-site. Cleaning trolleys were kept in designated locked cupboards. Covered trolleys are used for dirty linen. Residents and family interviewed report satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency/disaster management plans in place to guide staff in managing emergencies and disasters. The emergency/disaster management plan was put into practice with a recent power outage in January 2018. A corrective action plan was developed and implemented for any improvements required from the power outage procedure. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. Fire evacuation drills take place every six months, with the last fire drill occurring on 4 November 2017. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available. There are civil defence kits in the nurse's station in each unit, the kits are checked monthly. There is sufficient water stored (water tank) to ensure for three litres per day for three days per resident. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. Access by public is limited to the main entrance. The dementia community/unit has a secure entrance.

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 | The residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There are overhead heaters in resident rooms. |
| 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 the clinical manager and he 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 is combined with the quality meeting. There is external input as required from general practitioners, and the Bupa quality & risk team.

On 26 January they had a potential outbreak in the dementia community with four residents displaying symptoms of gastroenteritis. They immediately began isolation of the unit and notified Public Health. A toolbox talk was completed with all the staff across the care home, informed the families, informed the kitchen, laundry, cleaning staff and after four days they had no further residents showing symptoms. The clinical manager has also set up infection control and prevention boxes for all three areas. |
| 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 Bupa Stokeswood. 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 | 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 |

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.		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. The 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 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. Infections are included on Riskman and a monthly report is completed by 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 action plans (CAPs) are established where trends are identified, for example, in August 2017, Stokeswood residents UTIs were over KPI for 2 months. A corrective action plan was established, and they introduced a SIPS promotion in October concentrating on carer's getting residents to drink more per best practice and reduce UTIs especially coming into summer time. This was very successful and has continued. Their UTIs reduced. Other CAPs have been implemented for (but not limited to) increased RTIs January 2018 in the rest home, UTIs in the rest home and wound infections in the dementia community/unit in February 2018. All CAPs were evaluated for effectiveness to evidence a reduction in infections.

Standard 2.1.1: Restraint minimisation

Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirm their understanding of restraints and enablers. At the time of the audit, the service had two residents using three restraints (one bedrail and two lap belts) and three residents with four enablers (three bed rails and one lap belt). Staff training has been provided around restraint minimisation and management of challenging behaviours. |
| 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 (unit coordinator/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. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Ongoing consultation with the resident and family/whānau are evident. The files for two residents using restraint and two residents using an enabler were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). Falls risk assessments are completed six-monthly and interRAI assessment identifies risk and need for restraint. |
| Standard 2.2.3: Safe Restraint Use

Services use restraint safely | FA | The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The care plan reviewed of two residents with restraint, identified observations and monitoring. Restraint use is reviewed through the three-monthly evaluation, monthly restraint meetings and six-monthly multidisciplinary meeting which includes family/whānau input. A restraint register is in place, providing a |

		record of restraint use and is completed for residents requiring restraints and enablers.
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). Evaluation has occurred three-monthly as part of the ongoing reassessment for the residents on the restraint register and as part of their care plan review. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed three monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the regional restraint approval group teleconference meeting and information is disseminated throughout the organisation.

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 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The service provides regular in-service education and sessions have been provided that address all required areas. However, attendance numbers at trainings have been low. A competency programme is also in place with different requirements according to work type (e.g., support work, registered nurse, and cleaner). Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). RN competencies include assessment tools, BSLs/insulin administration, CD administration, moving & handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, CPR and T34 syringe driver.	There was no documented evidence of eight hours annual training being completed for all staff in 2017. Attendance at core in-service training has been low. For example, code of rights – 17 of 88 staff, abuse and neglect – 17 of 88 staff and cultural safety – 7 of 88 staff.	Ensure that staff complete at least 8-hours annually. Ensure staff that do not attend the in-service programme access training other ways, and this is documented. 180 days
Criterion	PA	The service uses an electronic medication	(i) A review of controlled drugs (CDs)	(i) Ensure CDs

1.3.12.1	Moderate	management system and robotic packs. There was a medication treatment room in each of the three units. Medications were appropriately stored, and stock rotated. The medication fridges in each unit had temperatures recorded daily and these were within acceptable ranges. Twenty medication charts were reviewed across the three units. Photo identification and allergy status were documented. Administration of medications was observed in the three units and all demonstrated safe practice. Documentation of prn medication included effectiveness. Shortfalls were identified around controlled drug management, medication documentation for a respite resident and follow-up of a resident that presented with a high BSL.	administered in the dementia community/unit identified examples where CDs were borrowed from other residents when stock was not on hand. (ii) The respite (rest home) resident had two faxed medication charts. It was unclear which was current. A discontinued medication by the GP was signed as given for the next two days following it being discontinued. The computerised medication signing chart listed medications in the robotic pack that were being signed for, however not all these medications were in the robotic pack or administered. (iii) One rest home resident had a BSL of 24 mmol, but this was not followed up.	are administered from either the stock hospital supply or the residents own supply; (ii) Ensure there is only one medication chart in place per resident and signing sheets reflect what is administered; (iii) Ensure BSLs identified as high or low are followed up as per policy 30 days
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.				
Criterion 1.3.5.2	PA Low	Ten resident files were reviewed for this audit. The respite file reviewed included a short-term nursing assessment and short-stay care plan. Of the ten resident files reviewed, the care plans for two dementia, one hospital and one rest home resident had shortfalls around documented interventions. A further two specific resident care plans were reviewed (one Māori resident and one Chinese resident that did not speak English). The Māori resident had a specific Māori care plan and the Chinese resident's care plan included interventions to support communication challenges and the use of a translator app that staff could describe.	The following shortfalls were identified in the care plans reviewed. (i) Two of three dementia level files had interventions updated in the care plan, but obsolete interventions were not signed out as not relevant; (ii) In one of three hospital files, the interventions around restraint and thickened fluids did not align in the care summary and LTCP. (iii) In one of three rest home files, interventions in the mobility section of the care plan had not been updated to reflect the resident's status as identified in the care plan evaluation. Interviews with caregivers and registered nurses supported knowledge around current care and support required for these three	Ensure care plans reflect current assessed needs and only include interventions to support current needs. 90 days
Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.				

			residents and therefore the risk has been identified as low.	
Criterion 1.4.2.6

Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | There is access to all communal areas and outdoor areas. There is outdoor seating and shade available in all areas. There is a large outdoor area off the dementia community/unit that extends around the dementia community/unit with areas of uneven surfaces. There is a plan in place to further landscape this secure outdoor area and remove uneven services and potential hazards. | There is a large outdoor area off the dementia community/unit that extends around the dementia unit. There are a number of external doors from the dementia community/unit to access the secure outdoor area, however (with the exception of one door) these are kept locked due to some of the outdoor paths and areas being uneven. Advised that residents in that outdoor area are supervised to minimise the risk of falls. There is a plan in place to further landscape this secure outdoor area and remove uneven services and potential hazards. | Ensure the outdoor secure area off the dementia community/unit is fully accessible and uneven services and hazards removed.

180 days |

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.

No data to display

End of the report.