# Bupa Care Services NZ Limited - Gardenview Rest Home

## Introduction

This report records the results of a Surveillance 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bupa Care Services NZ Limited

**Premises audited:** Gardenview Rest Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 12 March 2018 End date: 13 March 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:** 41

# 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 |
|  | 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

Gardenview Rest Home is part of the Bupa group of aged care facilities. The care facility has a total of 41 beds. During the audit there were 41 residents including one respite resident.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service is managed by a care home manager, who is a registered nurse (RN) and qualified and experienced for the role. The facility manager is supported by a clinical manager/RN. The GP interviewed spoke positively about the service provided.

This audit identified four shortfalls around preferred name, care plan interventions, activities and training.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Policies are implemented to support residents’ rights, communication and complaints management. Complaints and concerns have been managed appropriately 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, 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.

A comprehensive education and training programme is implemented with a current plan in place.

Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate staff cover for the effective delivery of care and support.

## 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. |

Residents’ records reviewed provided evidence that the registered nurses utilise the interRAI assessment and all residents have a care plan in place. Care plans demonstrate service integration and are reviewed at least six monthly. Resident files included medical notes by the contracted GP and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medication complete education and medication competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner.

An activities programme is implemented. The programme includes community visitors and outings and entertainment.

All food and baking are done on-site. 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. |

A current building warrant of fitness is posted in a visible location.

## Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents using either restraints or enablers. Restraint management processes are available if restraint is used.

## 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## 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 | 13 | 0 | 2 | 2 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| 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 families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaint’s register. No complaints have been lodged in 2018 (YTD). Six complaints were reviewed for 2017. All complaints had a noted investigation, timelines determined by HDC were met, and corrective actions (where indicated) were actioned and signed off as being implemented.  Complaints are linked to the quality and risk management system, they are reported to senior management through the electronic data base, and monthly reports from the care home manager. They are discussed in quality meetings. Discussions with relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns. |
| 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. | PA Moderate | Privacy is ensured, and independence is encouraged. Discussions with six relatives confirmed they were positive about the service in relation to their family member’s values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. On the day of audit one relative commented that they were referred to by a ‘nick name’ and staff were observed and overheard referring to residents in an inappropriate manner. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Six relatives 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. Five of six incidents/accidents forms selected for review indicated that family were informed (one had documented that they did not wish to be informed). Families interviewed confirmed they are notified of any changes in their family member’s health status.  Information provided to relatives on admission provides comprehensive information around secure dementia services.  Interpreter services are available if needed. Staff and family are utilised in the first instance. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Gardenview Rest Home is part of the Bupa group of aged care facilities. The care facility has a total of 41 beds, divided into two units suitable for secure dementia care. During the audit there were 41 residents, including one respite resident. Bupa's overall vision and values are displayed in a visible location. This includes the Bupa person-centred approach and the commencement of ‘person first’ (dementia second) training for all staff. 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 (RN) has been in the role for the last five years (away on the day of audit) and was previously the clinical manager. The manager is supported by a new clinical manager. The outgoing clinical manager was orientating the new clinical manager to the role at the time of audit. The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service. |
| 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 the operations manager, clinical manager(s) and five staff (three caregivers, one enrolled nurse, and one activities coordinator) 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.  Minutes of meetings document that all quality system data collected are collated and analysed with results communicated to staff (examples include: falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours infection control and internal audit outcomes). Monthly staff, quality and health and safety meetings occur as per the meeting schedule.  Two monthly resident and family meetings occur. The 2017 survey documents an improvement on 2016. Overall satisfaction went from 50 to 56 % and net promoter score improved from plus 35 to plus 42.  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 corrective actions with sign-off by the care home manager when implemented.  The health and safety team meet 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. Bupa facilities have been awarded ACC work safety management practice at a tertiary level (expiry 5 July 2018).  Goals for 2018 include person first (dementia second) training for staff, hazard identification, and also the reduction of falls and pressure injuries. Monthly meetings document that progress towards goals are discussed. |
| 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 care home manager, the clinical manager and/or registered nursing staff, clinical follow-up was evidenced in all six resident falls related accident/incident forms reviewed. Adverse events are analysed with results communicated to staff. 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 and documented in progress notes and care plans. Unwitnessed falls include neurological observations.  Discussion with two clinical managers and the operations manager confirmed awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications or coroner’s inquests since the previous audit. |
| 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. Six staff files reviewed (two caregivers, one RN, one clinical manager, one activity staff member and one cook) evidenced that reference checks were 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. The education programme being implemented is extensive and includes in-service training, competency assessments, and impromptu (tool box) talks. Caregivers are expected to complete an aged care education programme that meets the New Zealand Quality Authority (NZQSA) requirements. Not all staff have completed the Core Competencies level three, unit standards within timeframes.  The cook has completed a qualification in food safety and food hygiene. All 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.  One clinical manager and one RN have completed their interRAI training and the new clinical manager is in the process of interRAI training. |
| 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.  The care home manager (RN) works Monday to Friday and the clinical manager (RN) works Sunday to Thursday, and an additional RN works on Saturday and assists to cover leave. The care home manager and clinical manager share on call when not available on-site.  There is an RN on duty every AM shift and an RN or senior caregivers each PM shift.  The service is divided into two units, (one of 20 residents and one of 20 plus a respite bed). There is an entrance and foyer area between each unit. Each unit is staffed separately. All staff are rostered, so that they rotate different weeks across units to enable them to get to know all residents. The front door to the care park was always locked and both unit doors were open to the main foyer on the days of audit. There is a sitting area in the foyer where residents often sit. The admin office and managers office is located off the foyer and they are available to re-direct residents back to their correct unit if needed.  Each of the units have two caregivers on long shifts during the AM plus there is an enrolled nurse Monday to Friday across units. On the PM shift, both units have one caregiver on a long shift plus a 4.00 pm to 10.00 pm shift. There is a caregiver on each unit overnight plus a floater person between units.  Interviews with staff and family members identified that staffing is adequate to meet the needs of residents. |
| 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. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering medications at the time of audit. The service uses robotic packs and an electronic medication management system. The RN checks all medications on delivery against the medication and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are securely and appropriately stored. The medication fridges have temperatures recorded daily and these are within acceptable ranges.  All senior staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are not used.  Ten medication charts were reviewed. Photo identification and allergy status were on all charts. All medication charts for long-term residents had been reviewed by the GP at least three-monthly. |
| 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 | All meals at Gardenview continue to be prepared and cooked on-site. There is a six-weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to each dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.  Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Family surveys and interviews with relatives allow for the opportunity for relative feedback on the meals and food services generally. Family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.  Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded on each meal. The dishwasher is checked regularly by the chemical supplier.  There is evidence that additional nutritious snacks are available over 24 hours in both units. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | The registered nurses complete care plans for residents. Progress notes in all five files sampled had been completed each shift, and reflected the interventions detailed in the long-term care plans. Weekly to two weekly clinical reviews by an RN had been documented.  When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health. Discussions with families and notifications were documented in the resident file sampled in the family/whānau contact form.  The new resident and the respite resident both have a short-term care plan in place (short stay nursing assessment and care plan for the respite and a Bupa assessment book and care summary for the new resident). The care plan interventions for both these residents and two longer-term residents did not include all interventions.  On the day of audit, there were a total of 16 wounds recorded. The wounds were minor skin conditions, such as skin tears and fragile skin. There were no pressure injuries. All wounds had wound assessments, plans and ongoing evaluations completed, but evaluations were not always timely or fully complete.  Stocks of continence and dressing supplies are monitored by the RNs and ordered on a regular basis. Sufficient continence and dressing supplies are available. Registered nurses were able to describe access for wound and continence specialist input as required.  Weights are monitored monthly or more often, snacks are available, and dietitian available if needed. This was seen on all files reviewed.  Monitoring forms in use (sighted) include; fluid balance, continence diary, monthly blood pressure and weight monitoring, nutritional food and fluid monitoring record, two-hourly turning charts, and behaviour monitoring charts.  Families interviewed reported their needs were being met. |
| Standard 1.3.7: Planned 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. | PA Low | The service employs an activity coordinator (trained DT) Monday to Friday, an activities assistant for three days per week and an additional assistant for Saturdays. The activity coordinator has been in the role eight years. The activity staff have all completed the dementia standards.  Activities are provided six days a week and these are published weekly and posted in each resident’s room. Bupa has set activities on the programme calendar with the flexibility to add site-specific activities, entertainers and outings. Activities meet the abilities of both resident groups and younger persons. One-on-one time is spent with residents who are unable to, or choose not to join in the group activities. There are regular entertainers to the home and residents go on regular outings and drives. The service had a wheelchair hoist van.  The family completes a Map of Life on admission, which includes previous hobbies, community links, family, and interests. The individual activity plan is incorporated into the ‘My Day My Way’ care plan, and is reviewed at the same time as the care plan in all resident files reviewed.  Family have the opportunity to provide feedback on the activity programme through resident/relative meetings and satisfaction surveys. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed for long-term residents had been evaluated by registered nurses six-monthly. There is a comprehensive multidisciplinary review documented. The multidisciplinary review involves the clinical manager, RN, GP, any allied health member involved in individual resident care, activities staff and resident/family. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 28 February 2019). |
| 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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN with oversight from the clinical manager) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality and staff meetings. The infection control programme is linked with the quality management programme.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents using restraints or enablers. The clinical manager is the restraint coordinator and continues to maintain a restraint-free environment. |

# 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 1.1.3.2  Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies. | PA Moderate | 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. | One relative commented that they were referred to by a ‘nick name’ and had to ask more than once for this practice to cease. Staff were overheard calling one resident ‘dad’ (he was not the staff member’s dad, and this was not his preferred name). On two separate occasions (once in each wing) staff were seen and heard mocking resident’s accents and their cultural origin. | Ensure that staff are respectful of residents and their family’s cultural origin and refer to the resident by their preferred name.  30 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 Bupa education programme is being implemented and includes in-service training, competency assessments, and impromptu (tool box) talk. Of the 45 staff who work in the dementia units 40 have completed the Core Competencies level three, unit standards. Access to interRAI training has impacted on the timeliness of interRAI assessments for residents. | Five staff who work in the dementia unit have been employed over a year and have yet to complete the Core Competencies level three, unit standards. One of five resident files has an interRAI assessment that was not within timeframes, this is attributed to access to training for staff. | Ensure that all staff who work within the dementia unit have completed New Zealand Quality Authority (NZQSA) dementia standards within set timeframes. Continue to access interRAI training for staff.  90 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | All five resident files reviewed had assessments and care plans in place. Staff interviewed were aware of care needs for individual residents. Care plans reviewed did not include all interventions to support all assessed care needs. Wound care plans reviewed had not all been evaluated in a timely manner and were not all fully complete. | (i)The care plan for a newly admitted resident did not document all care and support needed as detailed in the progress notes. There were also interventions documented that did not relate to this resident’s care. The care plan also had another resident’s name in parts of the care plan. (ii) One respite resident and three longer-term resident’s care plans reviewed did not include de-escalation techniques to manage behaviours that challenge. (iii) Two behaviour monitoring charts reviewed did not document all behaviour exhibited. (iv) Of sixteen wound charts reviewed; four did not include a fully completed evaluation at each dressing change and seven had not been evaluated according to set timeframes. | (i)Ensure that care plans reflect the individualised care needs for each resident. (ii) Ensure that de-escalation techniques for behaviours that challenge are fully documented, (iii) Ensure behaviour monitoring charts are fully completed. (iv) Ensure that wound care evaluations are documented and completed according to set timeframes.  60 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The service employs activities coordinators and all residents have an activity plan as part of the care planning process. During the days of audit, not all residents were provided with meaningful activities. | On days of audit residents who did not go on the van trip did not have activities provided. Residents watching television did not have their chairs facing the television. | Ensure that there are meaningful activities in place for all resident and that residents are actively assisted to engage in activities.  90 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.