Bupa Care Services NZ Limited - Hayman Rest Home & Hospital

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.

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Hayman Rest Home & Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 14 March 2018 End date: 15 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: 104

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 Hayman Rest Home and Hospital provides rest home, hospital (geriatric and medical), dementia, residential disability services – intellectual and physical, and psychogeriatric levels of care for up to 110 residents. During the audit, there were 104 residents.

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

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to this facility. Quality initiatives are implemented which provide evidence of improved services for residents.

The service has addressed two of three shortfalls from the previous certification audit around activating enduring power of attorney for residents and aspects of care plan documentation. Improvements continue to be required in relation to the activities programme.

This surveillance audit identified a further improvement required in relation to staff training and environmental restraint.

There is one area of continuous improvement awarded around reducing the number of residents' falls.

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.

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. 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.

Services are planned, coordinated and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

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. An education and training plan is being implemented and includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 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.

Residents' records reviewed provided 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 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, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for the older person's consumer group.

All food and baking is 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.

The building has a current building warrant of fitness that is displayed 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.		Some standards applicable to this service partially attained and of low risk.

There were no residents who required enablers or restraints during the audit. The service has remained restraint-free since 2010.

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	17	0	2	1	0	0
Criteria	1	39	0	2	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 1.1.10: 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	There are established informed consent policies/procedures and advanced directives. Seven residents' files were reviewed: One from the psychogeriatric unit, two from the dementia unit (one from the men's unit and one from the women's unit), two rest home including one resident on a long-term support: chronic health conditions contract (LTS-CHC), two from the hospital, both younger person disabled (YPD). Copies of EPOA are available in the residents' files sampled. All seven files had an advanced directive and consents documented. Each resident file reviewed in the dementia and psychogeriatric units had an enacted enduring power of attorney (EPOA). The YPD residents also had an EPOA that was not necessarily enacted unless needed. This is an improvement from the previous audit.
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 at entry to the service. A record of all complaints received is maintained by the care home manager using a complaints' register. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set-forth by the Health and Disability Commissioner (HDC). Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms, and a suggestion box are placed at reception.

		Four complaints received in 2017/2018 were reviewed in their entirety and reflected evidence of responding to complaints in a timely manner with appropriate follow-up actions implemented. Two of these complaints were lodged with the DHB and one complaint has been lodged with HDC. Corrective actions have been implemented, which include (but are not limited to) strategies to respond to call bells in a timelier manner, staff disciplinary action where applicable, increasing the visibility of managers for residents and families throughout the day, placing cooling fans around the facility to address resident rooms that overheat in summer, and addressing care issues for residents. All required documentation relating to the complaints received have been submitted.
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 identified family are kept informed. Thirteen families interviewed (seven hospital, six dementia) stated that they are kept informed when their family member's health status changes. Regular family/resident meetings provide a venue where issues can be addressed. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. Staff and families are used in the first instance. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
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 Hayman Care Home provides hospital (geriatric and medical), rest home, dementia, psychogeriatric and residential disability - intellectual/physical for up to 110 residents. There were 11 rest home level residents and 44 hospital level residents in the two hospital/rest home units. There were 34 residents in the two dementia units (16 in the men's unit and 18 in the women's unit) and 15 residents in the psychogeriatric unit. Five residents were under the residential disability contract (four hospital and one rest home) – all with physical disabilities, and seven residents were under the long-term chronic condition contract (two psychogeriatric, two hospital, two rest home and one dementia). A vision, mission statement and objectives are in place. Annual goals for 2018 are documented and are regularly reviewed by the managers (care home manager and clinical manager).

		The service is managed by a care home manager who is trained as a registered nurse, but has not kept her practising certificate current. She has over 20 years of management experience in residential/intellectual disability and mental health service settings in the UK and in New Zealand and has been in her current role for three years. She is supported by an experienced clinical manager/registered nurse (RN) who has been employed at the facility for nine years and has been the clinical manager (CM) since 2013. The care home manager and CM are supported by a Bupa regional manager and two unit-coordinators/RNs. The care home manager and CM have 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	An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the Bupa regional manager. Discussions with the managers and staff reflected staff involvement in quality and risk management processes. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it 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. New policies or changes to policy are communicated to staff. There is a quality and risk management process in place. A new information technology system (Riskman) was implemented across Bupa facilities in August 2017. Monitoring for four levels of care (rest home, hospital, dementia, psychogeriatric) is completed each month. Benchmarking reports were being generated throughout the year to review performance over a 12-month period, but this data has not been made available since the implementation of Riskman. Work is reported as being underway at head office to provide staff with meaningful data. During the interim, the clinical manager is collecting and analysing data manually. An internal audit programme is in place. The audit schedule for 2017 and 2018 (year-to-date) reflects evidence of scheduled audits being completed in a timely manner. Audit summaries and action plans are completed as required, depending on the result of the audit. Results are discussed in staff meetings, evidenced in meeting minutes. Corrective actions are signed off to indicate implementation and audits are repeated until acceptable thresholds are reached (e.g., staff response to a fire drill). A number of quality improvements are being implemented, which include (but are not limited to); (1) ‘releasing time to care’ and (2) ‘person first – dementia second’. Falls prevention strategies include the analysis of falls events and the identification of interventions

		on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats and chair alarms. Toileting plans, and intentional rounding are examples of strategies being implemented. Staff are kept informed of residents at risk of falling. Residents' falls have continued to decline. Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the health and safety committee. One health and safety representative was interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. Bupa facilities have achieved a tertiary level for work safety management practice (expiry 31 March 2018).
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an accident and incident reporting policy. Adverse events are investigated by the registered nurse at the time of the event and by the clinical manager each month, evidenced in all fifteen accident/incident forms reviewed. Adverse events are linked to the quality and risk management programme. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations. Discussion with the care home manager and clinical manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided. A section 31 (coroner's inquest) was completed in March 2017 for an unexpected death and has been closed.
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	Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one RN, three caregivers, one kitchen assistant, one cleaner) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed (general and job-specific) orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register maintained for each training session and an individual staff member record of training. Staff were rostered for two eight-hour days of training in 2017, with an additional four hours

		of training provided for staff working in the dementia and psychogeriatric units. In addition, opportunistic education is provided. A competency programme is in place with different requirements according to work type. Core competencies are completed annually, and a record of completion is maintained. Twenty-seven caregivers are employed to work in the dementia and psychogeriatric units. Sixteen caregivers have completed the required dementia qualification. The remaining staff are working towards completing their qualification with four of these staff having been employed in either a dementia or psychogeriatric unit for over one year. Registered nurses are supported to maintain their professional competency. Sixteen registered nurses are employed and seven have completed their interRAI training. There are implemented competencies for registered nurses including (but not limited to) medication competencies.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a care home manager and a clinical manager (RN) who are on-site Monday - Friday. RN cover is provided 24 hours a day, seven days a week with a minimum of two RNs scheduled at any one time. Rest home/hospital: There are two rest home/hospital wings that are overseen by a unit coordinator/RN Monday - Friday. The pohutukawa wing (nine rest home and fifteen hospital) is staffed with one RN and three caregivers on both the AM and PM shifts (two long, one short). The kowhai wing (two rest home and twenty-nine hospital) is staffed with one RN and six caregivers (four long, two short) on the AM shift and four caregivers (three long and one short) on the PM shift. The night cover for the rest home/hospital wings is staffed with one RN and two caregivers (one for each wing). Dementia: A unit coordinator/RN oversees the dementia and psychogeriatric (PG) wings. The secure dementia wings are separated into men's (occupancy 16 residents) and women's (occupancy 18) wing. Six of the 39 dementia beds available are located in a third (secure) area which is in the centre of the men's and women's wings. These beds are for sleeping/resting purposes only with the residents placed in their respective area during the day time (link 2.1.1). One RN covers the AM shift in the dementia units with four caregivers split between the men's and women's wings on the AM and PM shifts. Nights are staffed with two caregivers. The staff area in the men's unit has visual access from the nurse's office to the swing bed area during the night shift. Psychogeriatric: The PG unit (occupancy 15) is staffed with one RN 24 hours a day, seven days a week. Two caregivers are rostered for the AM and PM shifts and one caregiver for the night shift.

		Separate laundry and cleaning staff are employed seven days a week. Interviews with staff, residents and family members identify 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 was one rest home resident self-administering an inhaler at the time of audit. A consent and assessment were documented and three-monthly reviews by the GP. Each of the units has a secure area for the storage of medications. 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 are recorded and fed back to the supplying pharmacy. Medications are stored securely and appropriately. The medication fridges have temperatures recorded daily and these are within acceptable ranges. No vaccines are stored on-site. All clinical 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 in place had a documented review by the GP and were all dated within the year. Fourteen medication charts were reviewed (four rest home, four hospital, two psychogeriatric and four dementia). 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. A selection of YPD charts were reviewed (three), none of the residents self-medicate but a process is in place should they wish to/are able to. Anti-psychotic management plans are used for residents using anti-psychotic medications when medications are commenced, discontinued or changed. The general practitioner reviews the anti-psychotic management plans for residents with stable behaviours and the psychogeriatrician reviews the management plans for residents with acute changes in behaviour.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where	FA	The service continues to provide a high standard of meal services. The cook discusses the meal with residents as part of a ‘walk round’. The cook stated that meals are adapted according to resident feedback. Residents interviewed also said the service provides ‘good meals’ and alternatives are offered.

this service is a component of service delivery.		The kitchen manager oversees the food services and is supported by kitchen staff on duty each day. The national menus have been audited and approved by an external dietitian. The main meal is at lunchtime. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in a bain marie to each kitchenette where they are served. The kitchen manager receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. There is evidence that additional nutritious snacks are available over 24 hours in all units. End-cooked food temperatures are recorded on each meal daily. Serving temperatures from the bain marie are monitored. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. A food control plan is in place.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Seven resident files sampled contained a long-term care plan that documented goals and interventions for identified needs. Resident care plans were resident-centred and multidisciplinary. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Overall care plans reviewed were comprehensive, including interventions to provide safe care and support for residents' with oxygen therapy, behaviours that challenge and reduced mobility. This is an improvement from the previous audit.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The registered nurses complete care plans for residents. Progress notes in all seven files sampled had detailed progress which reflected the interventions detailed in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. 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. On the day of audit there were 21 wounds (five hospital, six rest home, four psychogeriatric unit, and six dementia unit). The wounds included skin tears, scratches, surgical wounds and fragile skin. There were also four pressure injuries; two for a resident who was in hospital at the time of audit and two grade-one pressure injuries on one resident. All wounds had wound assessments, plans and ongoing evaluations completed. The registered nurse attends to the wound dressings, an assessment and evaluation is completed at each dressing change. Photographs are taken to reflect improvement or deterioration.

		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. 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. Residents and families interviewed reported their needs were being met. There was clear documented evidence of relative contact following GP reviews, incidents, infections, care plan reviews or any changes to resident health status. Observation during the audit and discussion with care staff and relatives confirmed that residents are dressed appropriately, and that hygiene care is undertaken for all residents. All staff reported that equipment is available to assist with resident care. They reported that the management team would ensure that additional equipment is purchased if needed.
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 Moderate	The service employs three activity staff who provide activities seven days a week. On or soon after admission, a social history is taken and information from this is fed into the care plan. This is reviewed six-monthly as part of the care plan review/evaluation and a record is kept of individual residents' activities. The family/resident completes a Map of Life on admission, which includes previous hobbies, community links, family, and interests. There are activity plans for each of the units (hospital, rest home, dementia and psychogeriatric). There is a list of activities posted for YPD residents, but these activities had not been provided and community linkages were not documented for this age group. This is a continued shortfall from the previous audit. A review of activity plans for the dementia and psychogeriatric wings evidences that resident routines were documented 24/7. All residents had individual activity plans. For all seven residents, an activities plan had been completed within timeframes, a monthly record of attendance to activities is maintained and evaluations are completed six-monthly. A monthly activities programme was displayed on noticeboards throughout the facility. There were general activities for all residents to join in and activities for more able residents. Families are invited to the resident meetings. The service also receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. Older residents interviewed stated they feel the activities are very good, and they are kept as busy as they want to be. Two younger residents did not feel that activities were always aimed for their age group.

		During the days of audit, activities were observed to be taking place in all units with caregivers and activity staff taking an active role.
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 (for residents who have been with the service for over six months). 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.
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 certificate is posted at the entrance to the facility (expiry 16 March 2018).
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	All laundry is done off-site at another Bupa facility. Dirty laundry is collected daily, and clean laundry is returned daily for folding and dispersing. Laundry and cleaning audits are completed as part of the internal audit programme. The service has a clothes labeller. The laundry staff member explained that they check all new resident's clothing and provide a labelling service for all new residents. They also check clothing routinely to make sure new clothes (and older clothes) are labelled with the resident's name. Both the laundry staff member and caregivers interviewed were able to explain that clothing is not shared between residents. All chemicals are labelled with manufacturer's labels. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. There are dedicated cleaning and laundry staff. Cleaning trolleys are well equipped and stored safely when not in use. Residents and relatives interviewed reported that they were satisfied with the laundry and cleaning services provided.
Standard 3.5: Surveillance Surveillance for infection is carried	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Infections

out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		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 reported since the previous audit.
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. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. Enablers are assessed as required, for maintaining safety and independence and are used voluntarily by the residents. At the time of the audit, the service had no residents using enablers or restraints. The clinical manager reported that restraint has not been used since 2010. Residents' falls have reduced significantly over the past year (link CI 1.2.3.6).
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.	PA Low	The clinical manager reported that restraint has not been used since 2010. Environmental restraint is practices within the dementia unit. There is no documented process around how this is managed.

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	A comprehensive staff education and training programme is being implemented. Attendance rates reflect staff attending a minimum of eight hours per year per staff member. Four caregivers (who have worked in dementia and psychogeriatric units for over one year) have not received a New Zealand Qualification Authority (NZQA) approved dementia qualification.	Four of the eleven caregivers who have not completed the required dementia qualification have been employed to work in either the dementia or psychogeriatric unit for over one year.	Ensure all staff who work in the dementia and/or psychogeriatric units complete a NZQA recognised qualification in dementia training within one year of employment. 90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated	PA Moderate	All resident files reviewed had an up-to-date individual activity plan and each unit had a monthly activity plan. However, the activities for the YPD group were not well documented	There was no specific activity plan for the YPD group of residents and community links for these residents were not established. There was a list of activities posted but these	Ensure that activities are provided for all resident groups.

to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.		or always provided.	had not been provided.	60 days
Criterion 2.2.1.1 The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.	PA Low	There is a secure six-bed unit within the dementia unit. This unit is beds only and is a mixed unit. Residents when up leave this area and for to their perspective (men's/women's unit) unit during the day and the bedroom unit remains locked. The service has not identified this as environmental restraint.	Six of the 39 dementia beds available are located in a third (secure) area which is in the centre of the men's and women's wings. These beds are for sleeping/resting purposes only with the residents placed in their respective area during the day time. This area is locked and resident need to ask staff to go through to their beds if they wish to lie down.	Ensure environmental restraint is discontinued in a secure dementia unit that should allow for freedom of movement 30 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Quality improvement data is regularly collected and collated. The organisation implemented a new information system (Riskman) in August 2018. Data is currently being collated manually while systems are being developed at head office. Data reflects significant improvements in the reduction of residents’ falls.	Falls continued to reduce in all areas of the facility when comparing 2016 statistics to 2017 (rest home 56.6% fewer falls, hospital 32.8%, dementia 38.9% and psychogeriatric 51%). Falls management strategies are focused on identifying those residents who are at risk and implementing strategies in a timely manner to prevent further falls. Staff training on falls prevention is ongoing. Staff are provided with visual data each month that highlights fall-free days. Fall-free days are celebrated. Reducing the number of falls while also maintaining a restraint-free environment remains an area of continuous improvement.

End of the report.