

Bupa Care Services NZ Limited - Whitby 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:

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| Legal entity: | Bupa Care Services NZ Limited |
| Premises audited: | Whitby Rest Home and Hospital |
| Services audited: | Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 3 December 2018 End date: 4 December 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: | 91 |

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 |
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|  | 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 |
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| | 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

Whitby Rest Home and Hospital is part of the Bupa group. The service is certified to provide hospital (medical, geriatric), psychogeriatric, rest home and dementia level care for up to 100 residents. On the day of the audit, there were 91 residents.

This surveillance audit was conducted against a subset of the 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 (non-practising). The care home manager has been in the role for one year and has fifteen years' experience of managing an aged care facility. She is supported by an experienced acting clinical manager who has been in the role for two months.

Three of the eight shortfalls identified as part of their previous surveillance audit have been addressed. These are around complaints documentation, medication charting and security of chemicals. Improvements continue to be required around: the quality system; timeliness of care plan documentation; implementation of care; food management; and training.

This audit has identified new areas requiring improvement around: cleanliness of the dementia unit; the process for self-medicating residents; evaluations; and use of communal clothing.

Consumer rights

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| 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 low risk. |
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Residents and family are informed, including of changes in resident's health. The care home manager and acting clinical manager have an open-door policy. Residents and relatives interviewed state the management and staff are very approachable should they have any concerns and are aware of the complaints process. There is a complaints policy and documented register.

Organisational management

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| 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 medium or high risk and/or unattained and of low risk. |
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Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and acting clinical manager are responsible for the day-to-day operations of the facility. Goals are documented for the service. Quality and risk performance is reported to the organisation's management team. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. There are human resources policies including recruitment, selection, orientation and staff training. An orientation programme is in place for new staff. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

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| 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. |
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Care plans are developed in consultation with the resident and/or family. Resident files include three-monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect guidelines. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner.

There is an activities programme implemented for each unit, (eg, rest home, hospital, dementia and psychogeriatric units), along with shared activities as appropriate. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done 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

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| 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. |
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The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained, with the two secure areas having accessible and safe secure outdoor areas. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Hot water temperatures are monitored.

Restraint minimisation and safe practice

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| 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. |
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There is a Bupa restraint policy that includes comprehensive restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were eighteen restraints and two enablers being 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.

The infection control surveillance programme is appropriate to the size and complexity of the service. Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected monthly in an electronic system. Infection control internal audits have been completed. There is an infection control officer that was appointed one week ago.

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) |
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| Standards | 0 | 9 | 0 | 3 | 6 | 0 | 0 |
| Criteria | 0 | 36 | 0 | 5 | 6 | 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) |
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| 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 |
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| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA | <p>The complaints procedure is provided to residents and relatives at entry to the service. There are complaint forms available at the entrance of the facility. A record of all complaints, both verbal and written is maintained by the care manager using a complaint 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.</p> <p>Discussions with the residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestions box are in a visible location at the entrance to the facility. The DHB requested follow up against aspects of two complaints received that related to aspects of care in the dementia unit. This audit identified the service is continuing to address these issues. Corrective actions have been established. Since the previous audit in March 2018, eight complaints have been received. All were reviewed with evidence of appropriate follow-up actions taken. There is written information on the service philosophy and practices particular to the different units. All complaints reviewed had documented evidence of the complaint outcome being communicated to the complainant or that the complainant was happy with the outcome. The previous partial attainment has been addressed.</p> |
| <p>Standard 1.1.3: Independence,</p> | PA Low | <p>There are policies and procedures in place around personal privacy, dignity and respect. However, the service provides communal net pants for residents. Privacy is ensured, and independence is encouraged. Discussions</p> |

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| <p>Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | | <p>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 identified 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.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Policies and procedures relating to accident/incidents, complaints and open disclosure policies 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. Three relatives (two dementia care and one psychogeriatric care) interviewed, confirmed that they are kept informed when their family member's health status changes. Five residents (three rest home and two hospital) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incident forms on Riskman have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fourteen accident/incident forms reviewed from November and December 2018, identified family were kept informed.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | FA | <p>Whitby Rest Home and Hospital is a Bupa facility that provides hospital (geriatric and medical), rest home, dementia and psychogeriatric level care for up to 100 residents. Occupancy on the day of audit was 91 residents. In the rest home unit, there are nine beds with nine rest home residents. In the hospital unit (dual-purpose), there are 41 beds with 40 hospital residents. In the dementia unit, there are 33 beds with 26 dementia care residents (including one younger person on a residential disability contract). All residents were on the ARC contract.</p> <p>In the psychogeriatric unit, there are 17 beds with 16 psychogeriatric residents. All residents were on the ARHSS contract.</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. Annual quality/health and safety goals for the facility have been determined (link to 1.2.3.6).</p> <p>The service is managed by a care home manager who is a RN (non-practising). The care home manager has been in the role for one year and has fifteen years' experience of managing an aged care facility. She is supported by an experienced acting clinical manager who has been in the role for two months. The acting clinical manager is a Bupa relief manager and relief care manager. She is also supporting the care home manager in her</p> |

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| | | <p>role.</p> <p>The management team are supported by one-unit coordinator, two registered nurse (RN) team leaders and a regional operations manager. All are experienced in dementia care and are supported by the Bupa dementia consultant.</p> <p>Care home managers and clinical managers attend annual forums and regional forums six-monthly. Both the care home manager and the acting clinical manager have maintained at least eight hours annually of professional development activities related to managing an aged care facility.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>PA Moderate</p> | <p>Bupa has a documented quality system and processes. The care home manager and acting clinical manager are responsible for the day-to-day operations of the facility and implementation of the quality system. 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. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>Quality and health and safety goals have been established for 2018. However, progress to meeting the goals has not been regularly reviewed and reported to staff.</p> <p>There is a Bupa meeting template agenda that ensures all quality data is reviewed, communicated and discussed, however quality, health and safety, staff and clinical meetings have not occurred as scheduled. This is a continued shortfall from the previous audit. Meetings that have been documented as taking place do not reflect discussion of quality and risk data.</p> <p>Adverse event data is collected and entered into the online Riskman system. However, this data has not been trended or analysed by the service to identify opportunities for improvement. An internal audits schedule is documented, however, not all audits have occurred as scheduled. Corrective actions identified from internal audit shortfalls have been documented, however, a number of these actions remain outstanding. This is a continued shortfall from the previous audit.</p> <p>Hazard identification forms and a hazard register are in place; however, the hazard register has not been reviewed as per policy. 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.</p> <p>There was an annual resident/relative satisfaction survey completed in June 2018 with results showing a decrease in satisfaction in all areas with a number of specific areas identified for improvement. The implementation of corrective action plans for areas requiring improvement was not evident. Staff meeting minutes did not reflect discussion of survey results.</p> <p>Falls prevention strategies are in place that includes the collection of falls data and the identification of</p> |

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| | | interventions on a case-by-case basis to minimise future falls. |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>An accidents and incidents reporting policy is being implemented with all incidents documented on Riskman. Incidents and accidents are not trended or analysed, and corrective actions are not fully completed for adverse events (link 1.2.3.6). Staff state they are informed regarding individual resident and staff adverse events during handovers and in staff meetings (link 1.2.3.6). A registered nurse conducts clinical follow up of residents. Fourteen incidents forms were reviewed for November and December. Unwitnessed falls with a suspected injury to the head include neurological observations, however, not all observations were completed as per policy (link 1.3.6.1). Discussions with the facility manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no outbreaks since the previous audit. A Section 31 report was completed appropriately for five adverse events and one pressure injury.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | PA Moderate | <p>There are human resources management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of current practising certificates are retained. Eight staff files (three registered nurses, two healthcare assistants, one activity coordinator, one cook and one maintenance) were reviewed and evidenced that reference checks were completed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The caregivers when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards.</p> <p>The in-service education programme is being implemented. Attendance at mandatory in-service training is frequently less than 20%. There are sixteen RNs and five have completed interRAI training. There are a number of competencies for RNs and care staff including (but not limited to): medication; blood sugar levels; manual handling; and restraint. However, not all competencies have been completed as required.</p> <p>Caregivers are encouraged to complete an aged care education programme and the service has access to a Careerforce assessor. The nursing staff attend external training provided by Bupa and the DHB. There are 26 caregivers that work in the dementia and psychogeriatric care units; six have completed the required dementia standards and seven have enrolled with Careerforce. Thirteen caregivers are yet to complete their dementia standards; ten of these staff have been employed in the units for over eighteen months. This is a continued shortfall from the previous audit.</p> <p>Staff are appraised annually on their performance.</p> |

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| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a care home manager, acting clinical manager and hospital unit coordinator who each work full-time from Monday to Friday. The care home manager and clinical manager are supported by two unit-coordinators and registered nurses. Registered nurse cover is provided twenty-four hours a day, seven days a week. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. Separate laundry and cleaning staff are employed seven days a week.</p> <p>The facility is split in to four units: hospital unit (Kowhai) 41 beds; rest home unit (Totara) nine beds; dementia care unit (Rata) 33 beds; and psychogeriatric unit (Kauri) 17 beds. On call is covered by the two-unit coordinators and acting clinical manager on a rotational basis.</p> <p>In the hospital Kowhai unit with 40 residents, in addition to the unit coordinator, there are two RN's and an enrolled nurse on morning shift, two RN's and an enrolled nurse on all afternoon shifts and one RN on at night. There are eight caregivers on duty in the morning (six long and two short), seven caregivers on afternoon shifts (five long and two short) and one caregiver on the night shift.</p> <p>In the rest home Totara unit with nine rest home residents, there is one caregiver on duty in the morning, afternoon and night shift.</p> <p>In the dementia care unit Rata with 26 dementia residents including one YPD, there is one RN on each morning, afternoon and night shift. There are four full shift caregivers on duty in the morning and afternoon shifts, and two caregivers on the night shift.</p> <p>In the psychogeriatric unit Kauri with 16 residents, there is an UC/RN on each morning shift and an RN on afternoon and night shifts. There are three caregivers (two long and one short) on morning shift, three caregivers (two long and one short) on afternoon shift and one caregiver on night shift.</p> <p>In addition to care staff, an activities coordinator is rostered on each unit Monday to Friday and weekend days across the PG and dementia unit.</p> <p>Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current</p> | <p>PA Moderate</p> | <p>Fourteen medication charts were reviewed on the electronic system from across the service. There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses an electronic medication system. The prescribing of medication meets legislative prescribing requirements. The medication charts reviewed identify that the GP has seen and reviewed the residents three-monthly. The previous findings around: controlled drug documentation; documentation of allergies; photos on medication charts; and medication round processes have been addressed. This audit has identified new shortfalls around medication</p> |

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| <p>legislative requirements and safe practice guidelines.</p> | | <p>management including: GP review of self-medicating assessments; fridge temperatures; dating of eye drops; and securing the dementia unit medication room.</p> <p>Education around safe medication administration has been provided (link 1.2.7.5). Staff were observed to be safely administering medications.</p> <p>Registered nurses interviewed could describe their role regarding medicine administration. Standing orders are not in use. There was one resident self-medicating on the day of audit.</p> <p>The GP reviews the use of anti-psychotic medication and if required makes a referral to the psychogeriatrician.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>PA Moderate</p> | <p>All baking and meals continue to be cooked on-site in the main kitchen. Meals are delivered in bain maries and a hot box to each unit where they are served. The kitchen 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.</p> <p>End cooked food temperatures are recorded prior to placement in the bain marie or hot box. Fridges and freezer temperatures are monitored and recorded daily. Foods in the main kitchen and dementia unit kitchen were not all dated, this is a continued shortfall from the two previous audits. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. On audit, all work surfaces were stainless steel and clean, but not the floor.</p> <p>There are snacks available across 24/7 in the dementia and PG units.</p> <p>Food service staff have completed on-site food safety education and chemical safety.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | <p>PA Moderate</p> | <p>Registered nurses (RNs) and caregivers, follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse [hospice nurse], or the mental health nurses). If external medical advice is required, this will be actioned by the GP or nurse practitioner. Not all nursing interventions were fully documented or implemented according to the care plan and or specialist direction. This is a continued shortfall from the previous audit.</p> <p>When a resident's condition alters, a registered nurse initiates a review and if required, GP and/or nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that indicates family were notified of any changes to their relative's health. The GP stated that the service provides appropriate clinical care.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and</p> |

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| | | <p>resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans are in place for residents with wounds. Wound care plan forms across all units were sampled and all wound care documentation has been fully completed. All wounds have been reviewed in appropriate timeframes. There were no residents with pressure injuries. The clinical manager described how to access specialist wound care advice.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The service continues to employ five activity coordinators who continue to provide activities for all residents across the facility. The activity coordinators have all completed the dementia standards. The caregivers and volunteers provide the set activities over the weekend.</p> <p>Activities are provided five days a week and activities are planned for weekends and after hours for the care staff to implement. There is a programme running in each of the four units (psychogeriatric, hospital, rest home and dementia) to meet the identified needs of the residents. This programme is printed for all residents and posted up on noticeboards. Many activities are integrated with residents moving from unit to unit for some activities. The younger person in the dementia unit has activities appropriate to their level of care.</p> <p>Activity staff informed that the activity plans are flexible and are often adapted to the needs and wants of the residents on the day.</p> <p>Bupa has set activities on the programme calendar with the flexibility to add site-specific activities, entertainers and outings. Activities meet the abilities of all resident groups. One-on-one time is spent with residents who are unable to or choose not to join in the group activities. There is a wide range of activities provided including: visiting pets, kindergarten groups, school and cultural groups that reflect the culture of many of the residents. Residents go on regular outings and drives in the Bupa Whitby wheelchair hoist van.</p> <p>Residents are encouraged to maintain links with the community and some attend church services in the community.</p> <p>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 into the 'My Day, My Way' care plan and is reviewed at the same time as the care plan, in all resident files reviewed.</p> <p>Residents/family have the opportunity to provide feedback on the activity programme through resident meetings and satisfaction surveys. Following the last survey, the service recommenced van outings and they now have a designated driver. Residents and relatives interviewed were overall happy with the activity programme.</p> |

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| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>PA Low</p> | <p>Files sampled for residents who had been in the service for over six months, demonstrate that the long-term care plans have been evaluated at least six-monthly or earlier if there was a change in health status. There is at least a three-monthly review by the GP. All changes in health status are documented and followed up.</p> <p>Reassessments have been completed using the interRAI assessment for all residents who have had a significant change in health condition. The three-monthly reviews of restraint had not been documented as per Bupa policy.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>There is a chemical/substance safety policy and waste management policy. Chemicals are stored safely in locked cupboards. Safety datasheets and product wall charts are available. Approved sharps containers are available and meet the hazardous substances regulations for containers. Management of waste and hazardous substances is covered during orientation of new staff. Chemicals were correctly labelled, and oxygen was stored securely and safely. Cleaner's trolleys were observed to be always locked and sluice doors secured. This is an improvement from the previous audit.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>PA Low</p> | <p>A current building warrant of fitness is posted in a visible location. Proactive and reactive maintenance (maintenance requests logbooks) are in place and maintained. A maintenance person is employed and on interview indicated a good understanding of providing a safe and appropriate environment for residents. Medical equipment including hoists and weighing scales, have been calibrated. Electrical testing and tagging has been completed annually. The hot water temperatures are monitored fortnightly at delivery point and are maintained between 43-45 degrees Celsius. The maintenance person is on call and there are contractors for essential services available 24/7.</p> <p>Each of the units has good visibility of residents as appropriate. Mirrors and CTV cameras are present in the psychogeriatric unit.</p> <p>The wide corridors and rails promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained with secure outside areas for the psychogeriatric unit and the dementia unit. There is outdoor furniture, seating and shaded areas. There is safe wheelchair access to all communal areas. The dementia unit has a strong odour in the corridors.</p> |

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| | | The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care. |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected monthly in an electronic system Riskman. Infection control internal audits have been completed. There is an infection control officer appointed one week ago. Data is not analysed, trends are not identified, and infection control is not discussed at staff meetings (link 1.2.3.6). There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Systems in place are appropriate to the size and complexity of the facility but are not fully implemented.</p> <p>There have been no outbreaks.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. Use of an enabler is voluntary; there were 13 hospital level residents and four residents in the psychogeriatric unit with bedrails as restraint. In the hospital there were three residents using lap belts (two using bedrails as well) and one resident using a lap belt only as restraint (link to 1.3.6.1 and 1.3.8.2).</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p> | PA Low | Individual named clothing is laundered and returned to residents’ rooms for use. Residents using continence products are supplied with net pants, however, these are not named for individual use. | Communal net pants were being used for hospital residents. | <p>Ensure net pants are named and for individual use only.</p> <p>90 days</p> |
| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | PA Moderate | Bupa has a robust documented quality system and processes. An annual internal audit and meeting schedule was sighted for the service. However, the schedules have not been fully implemented. Bupa Whitby collates quality data, however, there is no evidence of trends analysis and | (i) Not all facility meetings have been completed according to the meeting schedule. There were two caregiver meetings, one health and safety and two quality meetings documented for 2018. | (i) Ensure that facility meetings take place according to the meeting schedule. |

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| | | <p>identification of areas required for improvement (eg, high falls, skin tears and UTIs).</p> | <p>Clinical/RN meetings do not occur weekly as scheduled.</p> <p>(ii) Where staff meetings have occurred, the minutes do not reflect discussion of quality data including infection control trends, incident data including falls, skin tears, medications incidents or pressure injuries.</p> <p>(iii) Adverse event data is collected and entered into the online Riskman system. However, this data has not been trended or analysed by the service to identify opportunities for improvement.</p> <p>(iv) The internal audit schedule has not always been adhered to. Audits were not completed as scheduled for March through to June 2018. Seven out of nineteen corrective action plans required for audits not compliant, were not documented as completed or signed off, four of these were for November 2018.</p> <p>(v) Surveys of residents and families have been completed and results correlated at an</p> | <p>(ii) Ensure staff meetings include discussion of quality data.</p> <p>(iii) Ensure that all incidents and accidents are analysed, and action plans documented as needed, as per Bupa policy.</p> <p>(iv) Ensure that the internal audit schedule is adhered to and that all required corrective action plans are completed and signed off.</p> <p>(i) Ensure survey results are discussed at staff meetings and areas identified for improvement are actioned.</p> <p>(vi) Ensure that annual quality/health</p> |
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| | | | <p>organisational level along with identification of areas for improvement; however there is no evidence of further action or discussion with staff.</p> <p>(vi) Annual quality/health and safety goals for the facility have been identified; however, these have not been reviewed quarterly as per policy or discussed at facility meetings.</p> | <p>and safety goals for the facility are reviewed quarterly as per policy and discussed at facility meetings.</p> <p>60 days</p> |
| <p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p> | PA Low | <p>Bupa has established health and safety policies. An elected health and safety committee includes representatives from all areas. The committee has met once in April 2018, however, minutes did not evidence discussion or review of hazards or incidents. Bupa Whitby has a site-specific hazard register by area, however, the register has not been reviewed this year.</p> | <p>The hazard register sighted at audit has not been reviewed since January 2016.</p> | <p>Ensure the hazard register is reviewed by the health and safety committee at timeframes as per policy.</p> <p>90 days</p> |
| <p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to</p> | PA Moderate | <p>There is an annual education and training schedule being implemented, however attendance is very low. Annual competencies for medication, manual</p> | <p>(i) There are 26 caregivers that work in the dementia and psychogeriatric care units, six have completed</p> | <p>(i) Ensure that all caregivers that work in the dementia and</p> |

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| <p>consumers.</p> | | <p>handling, restraint and blood glucose levels are implemented; however, not all staff competencies have been kept up to date as required. There are 26 caregivers that work in the dementia and psychogeriatric care units. There are 10 caregivers who have not completed their dementia standards that have been employed for over 18 months.</p> | <p>the required dementia standards and seven are in progress of completing. Thirteen caregivers are yet to complete their dementia standards, ten of these staff have been employed in the units for over eighteen months</p> <p>(ii) Attendance at compulsory training sessions is less than 20%</p> <p>(iii) Expired competencies are evident for (but not limited to): medication (four staff), controlled drug management (six staff), blood glucose levels (seven staff), manual handling (11 staff) and restraint (most staff).</p> | <p>psychogeriatric care units have completed the required dementia standards</p> <p>(ii) Ensure all staff attend mandatory in-service training</p> <p>(iii) Ensure annual competencies are completed as required</p> <p>90 days</p> |
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | <p>PA Moderate</p> | <p>The services use an electronic medication system. The services have policies and procedures in place for the safe storage, prescribing and administration of medications. The GP was aware of the medication process and the process for the electronic medication system. Eye drops had not been dated on opening and fridge temperatures were not consistently recorded in the hospital unit. The dementia unit medication room was not adequately secured.</p> | <p>(i)The medication room in the dementia unit is situated off the secure kitchen. All staff have access to the secure kitchen and the medication room is not able to be locked.</p> <p>(ii) The fridge temperatures in the hospital wing had not been monitored daily as per policy</p> <p>(iii) The hospital wing</p> | <p>(i)Ensure that the medication room in the dementia unit can be locked</p> <p>(ii) Ensure that fridge temperatures are recorded per Bupa policy</p> <p>(iii) Ensure that eye drops are</p> |

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| | | | medication trolley contained eye drops which had not been dated on opening | dated on opening 60 days |
| Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | The service assists residents to self-administer medication where appropriate. Residents can secure medications in their room and there are robust policies and procedures in place to ensure safe self-medication. | One self-medicating resident in the hospital wing had not had their self-medication assessment reviewed since 2017. | Ensure that self-medicating residents have a three-monthly review of the self-medication assessment by the GP 60 days |
| Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Moderate | The service has an approved and verified food control plan (expiring September 2019). There are robust policies and procedures in place with supporting internal audits to ensure that food management and compliance is supported to a high level. Not all food was labelled and dated, and the main kitchen floor was not clean. | (i)The dementia unit had unlabelled and dated food in the fridge and the cupboards (ii) Food in fridges was not all dated and labelled in the main kitchen fridges (iii) Cooked meats in the main kitchen fridge was not dated on opening (iv) The main kitchen floor was not clean | (i)-(iii) Ensure all food is appropriately dated and labelled (iv) Ensure the kitchen is maintained at a high level of cleanliness 30 days |
| Criterion 1.3.3.3 Each stage of service provision (assessment, | PA Moderate | The service has put a process in place to ensure that ongoing interRAI assessments and evaluation of care | Two residents admitted since the previous audit (one in dementia level care | Ensure each stage of service |

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| <p>planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p> | | <p>plans are documented within set timeframes. However, recently admitted residents did not have the interRAI and long-term care plans completed within set timeframes.</p> | <p>and one at rest home level care) did not have the initial interRAI and long-term care plans documented within set timeframes.</p> | <p>provision is documented within set timeframes.</p> <p>30 days</p> |
| <p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p> | <p>PA Moderate</p> | <p>Care plans were in place in the files sampled, however, they were not all fully completed and/or addressed all resident needs. Interviews with registered nurses and caregivers demonstrate an understanding of the individualised needs of residents, but not all interventions were implemented according to clinical direction.</p> | <p>(i) Care plans did not document all care plan interventions. (a) In the psychogeriatric unit, one resident did not have interventions to manage aggressive episodes and one resident did not have intervention for restraint in the long-term care plan. (b) In the dementia unit, one resident did not have interventions for managing smoking.</p> <p>(ii) One initial assessment for a resident in the psychogeriatric unit was not fully completed.</p> <p>(iii) One resident in the psychogeriatric unit was observed smoking with no supervision.</p> <p>(iv) Two residents did not have monitoring according to timeframes (one resident in the hospital and one in the psychogeriatric unit). One resident in the</p> | <p>(i) Ensure that care plans document all care interventions.</p> <p>(ii) Ensure that assessments are fully completed.</p> <p>(iii) Ensure that residents are supervised in the psychogeriatric unit.</p> <p>(iv) Ensure that monitoring is undertaken according to the care plan.</p> <p>(v) Ensure that neurological observations are documented according to Bupa policies.</p> |

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| | | | <p>dementia unit had monitoring charts for weight and foods and fluids; these charts had not been completed.</p> <p>(v) Neuro observations were not completed according to Bupa timeframes for five of five residents post falls.</p> | 30 days |
| <p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p> | PA Low | <p>Resident files document a six-monthly evaluation of care and an interdisciplinary review. Resident with restraint do not all have a three-monthly evaluation of the restraint documented as per policy.</p> | <p>Two residents with restraint (one hospital and one resident in the psychogeriatric unit) did not have three-monthly reviews of their restraint documented as per policy.</p> | <p>Ensure that resident restraints are evaluated as per policy</p> <p>90 days</p> |
| <p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p> | PA Low | <p>The wide corridors and rails promote safe mobility with the use of mobility aids and transferring equipment. The external areas and gardens are well maintained with secure outside areas for the Psychogeriatric unit and the dementia unit. There is outdoor furniture, seating and shaded areas. There is safe wheelchair access to all communal areas. The dementia unit has a strong odour in the corridors.</p> | <p>The dementia unit had a strong malodour.</p> | <p>Ensure the dementia unit is odour free.</p> <p>60 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.