

Bupa Care Services NZ Limited - Glenburn Rest Home & Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Glenburn Rest Home & 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: 12 February 2019 End date: 13 February 2019
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:	96

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
Yellow	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
Red	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

Glenburn 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 103 residents. On the day of the audit there were 96 residents.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included review of policies and procedures; review of residents and staff files; observations; and interviews with residents, family, management, staff and a general practitioner.

The care home manager at Glenburn is an experienced manager (RN) who has been newly employed in the role. The home care manager has over 20 years' experience as a registered nurse, including seven years as a business and care manager in a different facility.

There are systems being implemented that are structured to provide appropriate quality care for residents. An orientation and in-service training programme continues to be implemented that provides staff with appropriate knowledge and skills to deliver care. Residents and family advised that the staff provide a caring and homely environment.

This audit identified shortfalls around; staffing, interventions and medication process.

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.
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Glenburn endeavours to provide care in a way that focuses on the individual residents' quality of life. There is a Māori Health Plan supporting practice. Cultural assessment is undertaken on admission and during the review process. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code of Rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are managed and documented. Residents and family interviewed, verified ongoing involvement with the community.

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.
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Glenburn is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Quality initiatives are implemented which

provide evidence of improved services for residents. There are four benchmarking groups across the organisation focusing on rest home, hospital, dementia, and psychogeriatric/mental health services. Glenburn is benchmarked in all of these. There are human resources policies to guide practice and an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. External training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. A sampling of residents' resident files included interRAI assessments and care plans for all residents. Planned activities are appropriate to the group setting. The residents and family interviewed, confirmed satisfaction with the activities programme.

Individual activities are provided either within group settings or on a one-on-one basis. Staff responsible for medication management had current medication competencies. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. There is a large well-equipped kitchen and the kitchen manager/chef oversees provision of the food service. All kitchen staff have completed food safety training.

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.



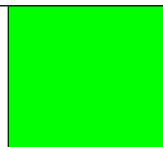
Standards applicable to this service fully attained.

The service provider's documentation evidences appropriate (reactive and planned maintenance) systems are in place to ensure the consumers' physical environment and facility is maintained. There are waste management policies and procedures for the safe disposal of waste and hazardous substances including sharps. Chemicals were stored safely throughout the facility and there is appropriate protective equipment and clothing for staff. Material safety datasheets are available.

Housekeeping staff maintain a clean and tidy environment. There is a large well-equipped laundry area with separate clean and dirty areas. There is a system in place to manage soiled linen appropriately and safely. The facility is appropriately heated and ventilated. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty always.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

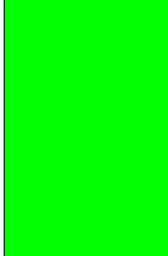


Standards applicable to this service fully attained.

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that is congruent with the definition in the standards. The process of assessment and evaluation of enabler use is the same as restraint and included in the policy. The service has eight residents on the register with restraint and no enablers. Restraint includes bedrails and seating restraint. Review of restraint use across the group is discussed at regional restraint

approval groups and at the facility in monthly restraint meetings. Staff are trained in restraint minimisation and restraint competencies are completed regularly.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control officer is supported by the Bupa quality and risk (CSI) team. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	2	1	0	0
Criteria	0	98	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code) brochures are accessible to residents and their families. Policy relating to the Code is implemented and care staff interviewed (six caregivers including one rest home, three dementia/psychogeriatric and two hospital; five registered nurses (RNs), one activities coordinator, one maintenance, two-unit coordinators - one dementia/psychogeriatric and one hospital; one kitchen manager/chef and one housekeeping staff; three managers) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme.</p> <p>Families and residents have been provided with information on admission which includes the Code. Staff have received training about the Code and competency questionnaires are also completed. Interviews with staff included discussion around ways that they demonstrate respect for privacy with support for residents to make choices as part of everyday life.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where</p>	FA	<p>There is an informed consent policy. Consent is included in the admission agreement and sought for appropriate events and treatment. Staff were observed to use verbal consent as part of daily service provision. Staff interviewed demonstrated an understanding of informed consent processes.</p>

<p>appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>Residents and relatives confirmed that consent issues are discussed with the relatives and residents on admission. Consent forms are shown to them on admission and thereafter as relevant. All residents' files reviewed included documented written consent.</p> <p>Residents deemed competent by the general practitioner have the choice to make an advanced directive. All residents in the dementia and psychogeriatric communities have an identified Enduring Power of Attorney and all have a needs assessment confirming that they have been assessed as requiring this level of care.</p> <p>In records reviewed, all competent residents have an advanced directive. The resident signs these. The general practitioner has made a decision for some residents as not for resuscitation, with this is noted as being a clinical medical decision.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code and information about advocacy services on entry. The pamphlet is included in the welcome pack.</p> <p>Interviews with care staff confirmed that residents and relatives are informed, and this was confirmed also by relatives and residents interviewed. Interview with residents confirmed that they are aware of their right to access advocacy. Interview with family members confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. In the files reviewed there was information on residents' family/whānau and chosen social networks.</p> <p>Family members of residents in the dementia or psychogeriatric communities confirmed that they are included in discussions, are regularly updated and asked about cares required. All stated that they also act as advocates for not only their family member, but also for others in the community if they see issues that should be escalated.</p> <p>The service has access to a Māori advocate from the Nationwide Advocacy service. The Māori advocate visits as required, and they also take staff training around abuse, neglect and cultural competence at least annually.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents can participate in as much as they desire and can safely do.</p> <p>Resident meetings are held at regular intervals with family invited to attend. There are also family forums held regularly throughout the year.</p>

		<p>The service encourages the community to be a part of the residents' lives in the service with visits from entertainers. An external entertainer was present on the day of audit, providing music for residents in the dementia and psychogeriatric communities.</p>
<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>There is a complaints procedure to guide practice. The care home manager has overall responsibility for managing the complaints process at Glenburn. A complaint management record has been completed for each of the three complaints received in 2018 and one in 2019. A record of all complaints per month had been recorded on the electronic register. The register includes relevant information regarding the complaint including date of resolution. Verbal complaints are included, and actions and response are documented. Complaints are reported to head office monthly.</p> <p>The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. There is a 'post box' at reception where complaints can be posted with this cleared daily Monday to Friday.</p> <p>Discussion with residents and relatives confirmed they were provided with information on the complaint process. Complaint forms were visible for residents/relatives in various places around the facility. There have not been any complaints from external authorities since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The information pack provided to residents on entry includes information on how to make a complaint, and information on advocacy services and the Code. There is the opportunity to discuss these services prior to, and during the admission process with the resident and family. Large print posters of the Code and advocacy information are displayed in the facility including at reception and in each community, which is referred to as a community (dementia, psychogeriatric, hospital and rest home communities).</p> <p>The families and residents have been informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p> <p>The quarterly resident meetings in each community and the six-monthly family forums are an opportunity for residents and family to discuss application of the Code and for staff to confirm access to advocacy services. Residents (five including three from the hospital – one identified as a young person with disabilities, and two from the rest home) and nine relatives interviewed (including three family from the psychogeriatric community; four from the dementia community and two from the hospital) confirmed information has been provided around the Code and the complaints process.</p>

<p>Standard 1.1.3: Independence, 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>FA</p>	<p>The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Ten resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and then integrated with the residents' care plan. There was evidence of family involvement.</p> <p>A tour of the facility confirmed there is the ability to support personal privacy for residents. The residents' personal belongings are used to decorate their rooms. Care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and they confirmed that they do not hold personal discussions in public areas. Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and families interviewed confirmed that residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. Care staff, family and residents interviewed, confirmed that there was no evidence of abuse or neglect.</p> <p>There is a non-denominational service each week and other individual opportunities for residents to access spiritual support of their choice. Specific ministers visit as per their choice and resident need. Residents and family interviewed confirmed that they are encouraged to access services in the community. Spiritual needs are individually identified as part of the assessment and care planning process and were documented in all ten files reviewed including files from the dementia and psychogeriatric communities.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is an organisational Māori health plan that aligns with contractual requirements. There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The Bupa Māori health policy was first developed in consultation with kaumātua and is utilised throughout Bupa's facilities.</p> <p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. There are three residents living at the facility who identify as Māori and their cultural needs and beliefs are documented in the care plans. Staff interviewed could describe how they refer to the care plan and ways in which cultural beliefs are upheld. There are four Māori staff with one who can speak te reo Māori fluently.</p> <p>Family/whānau involvement is encouraged in assessment and care planning. Visiting is encouraged. Links are established with disability and other community representative groups as requested by the</p>

		<p>resident/family.</p> <p>Examples of implementation of the Māori health plan and cultural policies were sighted during the audit. A staff member who identified as Māori welcomed the auditors onto the site with staff involved in the welcome. Staff were also observed to talk in Māori to residents for whom Māori was their preferred language. This was particularly evident in the psychogeriatric/dementia community with this used as a strategy to manage challenging behaviour.</p> <p>The auditor reviewed two resident records specifically to confirm that values and beliefs for Māori residents were assessed with the care plan documenting specific strategies and plans. The records confirmed that there was documentation as per the residents assessed needs.</p> <p>The service can access kaumātua and the kuia through Te Kawerau a Maki. Kaumātua and Kuia provide on-site support, for example, for blessings, karakia, remembrance quarterly.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whānau. Values and beliefs have been discussed at the initial care planning meeting and then incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled to assess if needs are being met. Family are invited to attend. Family assist residents to complete 'the map of life' which identifies interests and social likes. Staff stated that the map of life gives them a basis for discussion and as a reminder for them around cultural needs.</p> <p>Discussions with residents and relatives informed values and beliefs are considered. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p> <p>There are eight residents with very limited English. There are staff on site who can speak those languages, and the service makes every attempt to put these staff members with the resident to provide cares. Staff can access interpreting services if required through a nationwide interpreting service.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. The Code of Conduct is included in the employee pack. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents.</p> <p>Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment or financial exploitation. Professional boundaries are reconfirmed through education and training sessions and staff meetings, and managers stated that performance</p>

		<p>management would address any concerns if there was discrimination noted.</p> <p>Interviews with staff confirmed an understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Services are provided at Glenburn that adhere to the health and disability services standards. There is an organisational policy and procedure review committee to maintain currency of operating policies. All Bupa facilities, including Glenburn, have a master copy of policies and procedures as well as related clinical forms.</p> <p>There is a well implemented education programme with staff also supported through regular 'toolbox' talks. These are often in response to queries raised or where corrective actions have been identified. A number of core clinical practices also have education packages for staff which are based on their policies.</p> <p>Quality data is completed and documented on Riskman. The clinical indicators are analysed at Glenburn. Information is provided to staff on the trends and corrective action plans when indicators are above the benchmark (eg, skin tears, falls). Actions were reviewed and signed off with the clinical manager and the care home manager both involved in review and discussion. Bupa quality and risk management systems are being implemented at Glenburn.</p> <p>The care home manager is newly appointed and has already started to implement change. Key areas of focus are to the external environment, food services and activities. Staffing is also being reviewed particularly for the dementia and psychogeriatric community.</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>There is an incident reporting policy to guide staff on their responsibility around open disclosure. Incident forms reviewed identified that family had been notified following a resident incident. Relatives stated that they are informed when their family members health status changes.</p> <p>There is an interpreter policy and contact details of interpreters are available. Managers described accessing interpreting services when required.</p> <p>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. The information pack is available in large print and this can be read to residents.</p> <p>Information specific to the psychogeriatric and dementia community is provided to family on admission as part of the admission pack. The managers and registered nurses described discussing the philosophy of the dementia community and psychogeriatric community with relatives when they enter</p>

		<p>the service, and this was confirmed by relatives interviewed. Additional information is available if required.</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>	<p>FA</p>	<p>Glenburn is a Bupa facility which provides hospital, rest home, dementia and psychogeriatric level care for up to 104 residents. Occupancy on the day of audit was 96 residents.</p> <p>The service is divided into communities. There are 26 rest home level beds with an occupancy of 23 on the day of audit; 52 hospital level beds with an occupancy of 50; 13 dementia level beds with an occupancy of 12 (one room in the dementia level community is designated as being for a resident requiring respite at this level and this was vacant during the audit); 13 psychogeriatric level beds with an occupancy of 11. There are two separate wings of the secure Koru community (one identified for dementia level of care and one as psychogeriatric level of care) with both operating as separate communities.</p> <p>Residents included four young people with a disability who have been assessed as requiring hospital level of care by Taikura Trust; two residents in the psychogeriatric community identified as being under a long-term chronic health contract.</p> <p>There are no dual-purpose beds.</p> <p>The philosophy of the service includes providing safe and therapeutic care for residents requiring specialised hospital level care (psychogeriatric), dementia care, rest home care and hospital care. Resident care plans reflected the service's resident centred approach to care and support. Bupa have identified six key values that are displayed on the wall at Glenburn. There is an overall Bupa business plan and risk management plan and a documented purpose, values, and direction.</p> <p>The care home manager at Glenburn is an experienced manager (RN) who has been newly employed in the role. The home care manager has over 20 years' experience as a registered nurse including seven years as a business and care manager in a different facility. The manager is supported by a clinical manager (registered nurse) who oversees clinical care. The clinical manager has been in the role for 10 years with prior experience in surgical nursing. There are unit coordinators who provide day to day leadership and oversight in each community.</p> <p>The managers are supported by the wider Bupa management team that includes an operations manager. Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual forums and regional forums six monthly. The managers have maintained at least eight hours annually of professional development activities related to management of services such as these.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During a temporary absence, the clinical manager provides cover for the manager's role, supported by the operations manager. The operations manager confirmed that they increase the amount of time they are on site if the care home manager is on leave. The service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</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>FA</p>	<p>Glenburn implements the Bupa quality and risk management system which is designed so that key components are linked to facility operations. The quality committee meet two monthly and outcomes are then reported across the various other meetings.</p> <p>There are meetings to ensure that all are engaged in discussion and review of quality and risk data. Meeting minutes reviewed include discussion about the key components of the quality programme. Policy review is coordinated by Bupa head office. The service has comprehensive policies/procedures to support service delivery including a policy around meeting interRAI requirements. A document review process is in place.</p> <p>The quality programme includes an annual internal audit schedule that is being implemented at Glenburn. Audit summaries and corrective action plans are documented where a noncompliance is identified. Issues and outcomes are reported to the appropriate committee. Corrective action plans reviewed, showed documentation of resolution of issues with these closed out in a timely manner. Monthly and annual reviews are completed for all areas of service.</p> <p>Meetings include the following: two monthly head of department, community meetings, quality, kitchen, household, health and safety and infection control; monthly staff meetings; two monthly clinical review meetings. These meetings also serve as forums to review progress towards goals. Glenburn participates in the organisations benchmarking programme that monitors key aspects of care. Discussions with registered nurses and caregivers confirmed their involvement in the quality programme. Resident/relative meetings are held.</p> <p>There are projects in place to progress improvements for residents and to service delivery. This includes a review of the activities programme which has seen better input into the programme from key stakeholders and improvements to staffing with an 81% level of satisfaction from residents at the last survey; implementation of weekly clinical review meetings where the care home manager, clinical manager, unit coordinator(s) and the duty registered nurse review clinical issues in each community. Review on residents on anti-psychotic medications now occurs every Friday.</p>

		<p>There is an annual satisfaction survey completed. The report from the survey within the last year (July/August 2018) confirmed a 70% overall satisfaction with the service with relatives giving an 80% to 86% rating of satisfaction for the dementia and psychogeriatric communities.</p> <p>The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place, including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Bupa belongs to the ACC Partnership Programme and have attained tertiary level at audit. Bupa continues to update their documents to meet the new Health and Safety at Work Act 2015. Staff are informed of these changes through policy and work instructions which are disseminated to each part of the business.</p>
<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>Glenburn collects incident and accident data on the prescribed form. Twenty forms reviewed had been completed comprehensively, reviewed by the clinical manager and signed off in a timely manner. Monthly analysis of incidents by type has been undertaken by the service and reported to the various staff meetings. Data was linked to the organisation's benchmarking programme and used for comparative purposes. Corrective action plans are completed when the number of incidents has exceeded the benchmark with these signed off when strategies and actions have been implemented. Neurological observations are not always completed as per policy for any resident with a fall involving a head injury or for an unwitnessed fall (link 1.3.6.1).</p> <p>A review of completion of incident and accident forms in April 2018 as part of the internal audit programme, evidenced a 95.8% completion of those reviewed.</p> <p>Senior management are aware of the requirement to notify relevant authorities in relation to essential notifications.</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</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and skills. A copy of practising certificates is kept. Ten staff files were reviewed (the care home manager, clinical manager, two unit coordinators, two registered nurses, activities coordinator, cook and two caregivers) and included all appropriate documentation. Staffing</p>

<p>the requirements of legislation.</p>		<p>levels are stable with some staff having been employed for a number of years.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. There was a completed in-service calendar for 2019 which exceeded eight hours annually for staff who attended the 2018 training offered.</p> <p>Caregivers have completed either the national certificate in care of the elderly or have completed or commenced the Careerforce aged care education programme.</p> <p>There is a total of 98 staff employed at the service. The following staff are employed to support residents at Glenburn: 62 caregivers; nine registered nurses plus three- unit coordinators (five are interRAI trained); four full or part time activities staff; and nine household staff (laundry kitchen or cleaning).</p> <p>There are a total of 34 caregivers and registered nurses who work in the dementia and psychogeriatric communities (noting that nine have completed the training but do not normally work in this area). Twenty-five have completed the required NZQA dementia standards level four and 12 are enrolled in the training.</p> <p>The clinical manager and registered nurses attend external training including conferences, seminars and sessions provided by Bupa and the local district health board as sighted in staff files reviewed.</p>
<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>PA Low</p>	<p>There is an organisational staffing policy that aligns with contractual requirements. The Wage Analysis Schedule (WAS) is based on the Safe indicators for Aged Care and Dementia Care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether hours are over and above.</p> <p>There is a minimum of two registered nurses plus care staff on every shift. This includes one registered nurse in the psychogeriatric community at all times (who also covers the dementia community when required) and at least two registered nurses in the hospital 24 hours per day (who provide cover to the rest home). The dementia community and psychogeriatric community have a shared office with windows into the lounge of each community and are connected with call bells alerting through both services. Interviews with caregivers from across all community informed that the nursing staff and management are supportive and approachable. Staff interviewed informed there is sufficient staff on duty at all times apart from at night at times in the dementia or psychogeriatric community.</p> <p>A review of rosters confirmed that there are sufficient staff rostered and staff are replaced when on call.</p>

		There is an on-call process for after hours and staff are aware of how to escalate any concerns.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry, into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in locked cupboards.</p> <p>Care plans and notes are legible and where necessary signed and dated by a registered nurse. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident files demonstrate service integration. There was an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Admission policies and processes are documented. Prior to entry all potential residents have a needs assessment completed by the needs assessment and coordination service to assess suitability for entry to the service. Residents receive an information pack outlining the services able to be provided, the admission process, and entry to the service.</p> <p>Residents and relatives interviewed, confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the care home manager or clinical manager. Signed admission agreements were sighted in all ten resident files reviewed (two from the dementia community, two rest home, three psychogeriatric community and three hospital level). All resident files, including the dementia and psychogeriatric resident files included a NASC assessment and approval for the service level.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA Moderate	<p>The service has a robust medication management system, policies and procedures in place. Regular internal audits are undertaken to ensure compliance. Prescribed medications are delivered to the</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>facility and checked on entry by the RN. Medications were appropriately stored for each of the hospital communities (upstairs and down stairs), the rest home and in the medication rooms shared by the psychogeriatric and dementia units. The fridge temperatures are conducted and recorded daily. All staff (RNs and senior caregivers) authorised to administer medicines have current competencies. There is an electronic medication management system in place. All staff administering medications had completed training for the electronic system.</p> <p>Medication rounds were observed in each of the communities and all evidenced good practice according to policy, however the administration of covert medications has not been documented according to Bupa policies. Administration records are maintained, as are staff specimen signatures. One resident who self-administers medications in the rest home had an assessment and consent and lockable storage. Standing orders had been reviewed and approved annually for the rest home (only the rest home has standing orders).</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>FA</p>	<p>All food and baking is prepared and cooked on-site. The kitchen manager/cook is supported by two cooks and four kitchen assistants. Staff have been trained in food safety and chemical safety. There is an organisational four weekly seasonal menu that had been designed in consultation with the dietitian at an organisational level. Meals are delivered via hot box (purees) and bain-maries (main meals) to each of the four areas. The food control plan is in the process of verification.</p> <p>The kitchen manager/cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. The kitchen manager interviewed stated they provide meals daily that cater to Indian, Asian and Pacific Island residents currently. Special diets such gluten free, dairy free, diabetic desserts and pureed/soft diets are provided. Nutritious snacks are available 24 hours in the dementia and psychogeriatric community.</p> <p>Freezer, chiller temperatures and end cooked temperatures are taken and recorded daily. Corrective actions are in place and sighted for any issues. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Kitchen staff were observed to be wearing appropriate personal protective clothing.</p> <p>Residents have the opportunity to provide feedback on the meals through resident meetings, survey and direct contact with the kitchen manager or cooks. Residents and families interviewed were overall happy with the meals provided.</p> <p>Meals were observed in each of the communities. Staff were observed assisting residents as needed and meals were nicely served and of an appropriate temperature.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reasons for declining service entry to residents should this occur and communicates this to residents/family/whānau. Anyone declined entry is referred to the needs assessment service or referring agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The facility has embedded the interRAI assessment protocols within its current documentation. Risk assessments and care plans were completed and were detailed for all the resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all long-term resident files. All ten resident files reviewed identified that the Bupa risk assessment book had been completed on admission and ongoing interRAI based assessments completed six-monthly as part of the evaluation. Additional assessments for management of behaviour, pain and wound care were appropriately completed according to need.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>All resident care plans sampled were resident-centred. Interventions overall support assessed needs (link 1.3.6.1). Family members interviewed confirmed care delivery and support by staff is consistent with their expectations and they and/or the resident are involved in the care planning and review process. Residents agreed that their care was discussed with them. The interRAI assessment process informs the development of the resident's care plan. Short-term care plans are in use for changes in health status, are signed off once completed or transferred to the long-term care plan.</p> <p>Caregivers interviewed reported they accessed the resident file to review care plans and write progress notes and they found the care plans easy to follow. Specific care plans were implemented for specific health needs, including (but not limited to) dementia care, medical needs, diabetes, pressure injury management and prevention, and wounds.</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</p>	PA Low	Registered nurses and caregivers, follow the care plan in the resident file and report progress against the care plan at handovers. If external nursing or allied health advice is required, the RNs will initiate a referral (district nurse, hospice nurse, mental health or other specialist nurses). If external medical advice is required, this will be actioned by the GP. Caregivers and RNs interviewed stated there is adequate equipment provided, including continence and wound care supplies. Sufficient continence

<p>desired outcomes.</p>		<p>products are available and 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. Wound care plans, behaviour plans, pain management and specific resident plans (bowel management) are evident.</p> <p>Interventions were being implemented for one resident with weight loss, but not documented in the care plan. Neurological observations were not always documented as per Bupa policy.</p> <p>Each of the communities (units) have their own wound folder and wound logs with 24 wounds logged across the communities. This included three current pressure injuries. Wound management plans were fully documented for all current wounds; wound re-assessment and rationale for when changes were made to the wound plan were fully documented with each dressing change. All wounds have been assessed and reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the DHB wound care nurse specialist if required. Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents.</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 activities team includes five activities coordinators who oversee the activities programme provided across seven days per week. A physiotherapy assistant assists with walking and exercise groups.</p> <p>There is a monthly programme with a range of activities offered that are age appropriate. There is separate rest home, hospital, dementia and psychogeriatric weekly programmes (4-6 hrs per day in each area) with activities that meet the needs and preferences of the four resident groups. Residents may choose to attend any activities offered such as entertainment. Variations to the group programme are made known to the residents. Many activities are integrated such as entertainment, as observed on the day of audit. Variations to the group programme are made known to the residents. The programme for each community covers physical, cognitive, social and spiritual needs. There are regular visiting entertainers and community groups. Activities provided are meaningful and include (but are not limited to): newspaper reading, current affairs, reminiscing, crafts and quizzes. There are weekly van outings into the community areas of interest for residents including vans trips for residents in the secure dementia and psychogeriatric communities.</p> <p>There is a specific programme for the dementia and psychogeriatric residents. Younger persons can join any activities on offer and are assisted and encouraged to access community groups (of interest) and events. One younger person described how the service assists with access to the shopping mall and library.</p> <p>Families and resident praised the activity programme.</p> <p>A resident activity assessment is completed on admission. Each resident has an individual activity plan which is reviewed six-monthly. Recreational preferences are age appropriate and meet the individual</p>

		<p>needs for aged care.</p> <p>The service receives feedback on activities through one-on-one feedback, residents' meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans were evaluated by the RN within three weeks of admission. Care plans reviewed had been evaluated by registered nurses six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The GP reviews residents at least three-monthly or when there is a change in health status. The family members interviewed confirmed they are invited to attend the GP visits and multidisciplinary care plan reviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. GP reviews are requested using the ISBAR form and kept on the resident files. The GP interviewed stated that referrals were competent, timely and included all the detail needed to assist him.</p> <p>The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Discussions with registered nurses identified that the facility has direct access to services including DHB nurse specialists, podiatrist and physiotherapy (contracted) services.</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>	FA	<p>There are policies in place to guide staff in waste management. All staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety datasheets are available.</p>
<p>Standard 1.4.2: Facility</p>	FA	<p>The building has a building warrant of fitness dated 24 September 2018 for one year. Reactive</p>

<p>Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>maintenance and a 52-week planned maintenance schedule in place has been maintained, including air temperature, sling checks, and monthly equipment checks. There is a full-time maintenance person employed. Medical equipment has been calibrated. The hot water temperatures are monitored weekly and are maintained between 43 – 45 degrees Celsius. There are contractors for essential service available 24/7.</p> <p>Residents were observed moving freely around the areas with mobility aids where required. The external areas and garden landscaping has been completed and are well maintained. There is outdoor furniture and seating and shaded areas. There is wheelchair access to all areas.</p> <p>The caregivers and RNs interviewed stated they have all the equipment referred to in care plans necessary to provide care.</p> <p>The dementia community and psychogeriatric communities have lounge areas designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas and seating alcoves that provide privacy when required. There is a safe and secure outside walking and garden areas, which are easy for residents to access.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate toilets and showers in the rest home, hospital, dementia and psychogeriatric communities. Resident rooms in the rest home, dementia and psychogeriatric communities have hand basins. In the upstairs hospital community, all rooms have a shared ensuite between two residents. In the downstairs hospital community residents' rooms have toilet ensuites and hand basins. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. There are sufficient numbers of communal toilets and mobility bathrooms. Communal, visitor and staff toilets are available and contain flowing soap and paper towels. Communal toilets and bathrooms have appropriate signage and locks on the doors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. Mobility aids can be managed in ensuite facilities. The lounge areas are spacious and can be used for activities and small groups as well as for private social interaction. There are smaller lounges for residents who prefer quiet, low stimulus areas. Residents requiring transportation between rooms or services are able to be moved safely from one area to another. Staff interviewed reported that they have adequate space to provide care to residents.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>All bedrooms are single. The rest home and hospital bedrooms are spacious enough to manoeuvre transferring and mobility equipment to deliver care safely and easily. The bedroom doors are wide enough to allow ambulance access if required. The dementia care and psychogeriatric community bedrooms are spacious. Residents are encouraged to personalise their bedrooms as desired.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are cleaning policies and processes. The cleaner's cupboards are designated areas and are lockable for storage of chemicals. All chemicals are labelled and stored securely. Cleaning and laundry audits occur as per the internal audit system. The laundry and cleaning rooms are designated areas and clearly labelled. There are sluice rooms for the disposal of soiled water or waste. These are locked when unattended. Residents interviewed were satisfied with the standard of cleanliness in the facility and with the current laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. There is a first aid trained staff member on every shift. The facility has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs were in place. The service has alternative gas facilities for cooking in an event of a power failure with a backup system for emergency lighting and battery backup. Oxygen cylinders are available. There is a civil defence kit in the facility and stored water. Call bells are evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is secured at night and a security firm provides two checks each night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. The facility has central heating that is thermostatically controlled. All bedrooms and communal areas have at least one external window.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme is appropriate for the size and complexity of the service. The scope of the infection control programme policy and the description of the infection control programme are available. There is a job description for the infection control (IC) coordinator and clearly defined guidelines. The infection control programme is linked into the quality management programme.</p> <p>The infection control (IC) committee meets bi-monthly at Glenburn. The quality meetings reviewed also included a discussion of infection control matters. The IC programme is reviewed annually through the regional meetings and head office. The facility has developed links with the general practitioners, local laboratory, the infection control and public health departments at the local DHB. Bupa has a regional infection control group (RIC) for the three regions in NZ.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control committee is made up of a cross section of staff from all areas of the service. The facility also has access to an infection control nurse specialist, public health, general practitioners and expertise within the organisation.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. There is also a 'scope' of the infection control programme, standards for infection control, infection control prep, responsibilities and job descriptions, waste disposal, and notification of diseases. Infection control procedures developed and contained in the kitchen, laundry and the housekeeping manuals incorporate the principles of infection control. These principles are documented in the service policies contained within the infection control manual. External expertise can be accessed as required, to assist in the development of policies and procedures.</p>
<p>Standard 3.4: Education</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC coordinator (clinical manager) is suitably skilled and trained to manage infection matters with</p>

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>external training around infection control in the past year.</p> <p>There is also a national teleconference six monthly for Bupa services and the clinical manager and one other registered nurse attend the meetings via teleconference.</p> <p>The orientation package for new staff includes specific training around hand washing and standard precautions. There has been infection control training provided as part of the annual education schedule. Tool box sessions are also used opportunistically to maintain staff knowledge. Resident education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs.</p>
<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>	<p>FA</p>	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. The IC coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files.</p> <p>Infections are included on a monthly register and a monthly report is completed by the IC coordinator with this tabled at relevant meetings. Infection control data is collated monthly and reported at the quality and infection control meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There has been an outbreak of scabies in September 2018 and a gastro enteritis outbreak since the last audit. Both have been well documented with appropriate authorities involved and notified. Documentation confirmed that the general practitioner has been actively involved in the outbreaks and specialist staff from Bupa have provided appropriate advice and support.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a regional restraint group at an organisation level that reviews restraint practices. The Glenburn quality committee is also responsible for restraint review and use. There is a documented definition of restraint and enablers. There are clear guidelines in the policy to determine what is restraint and what is an enabler. The restraint policy includes comprehensive restraint procedures.</p> <p>There are no residents with enablers.</p> <p>There are a total of nine residents using restraint. This includes four hospital residents with bed rails and T belts; two residents in the hospital using a bed rail; two residents in the psychogeriatric</p>

		community with a bean bag or low bed (at the family request). The service has had a focus on restraint minimisation and has not used restraint in the rest home or dementia community in the last year. One resident in the psychogeriatric community has had a low bed since July 2018 and the staff are currently trialling other strategies to prevent falls including making sure that staff understand the policy and approach, know how to use equipment, improving understanding for family members and managing their expectations, increase training and individualised training around the needs of that resident, understanding of risks and use of other strategies to manage behaviours.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint coordinator is the clinical manager (registered nurse). The service has a restraint coordinator position description. Assessment and approval processes for restraint interventions included the restraint coordinator, clinical manager, registered nurses, resident or family representative and medical practitioner. Restraint use and review is part of the quality team meeting.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes comprehensive assessments for residents who require restraint interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family. The restraint coordinator, clinical manager, registered nurses, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. Assessments and approvals for restraint were fully completed. These were sighted in the three files reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are followed. There is an assessment form/process that was completed for all restraints. The three files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular two hourly monitoring (or more frequent) were present in the files reviewed. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register which had been updated each month.

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. In the three restraint files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and medical practitioner. Restraint practices were reviewed on a formal basis every month by the facility restraint coordinator at quality and staff meetings. Evaluation timeframes were determined by risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews were completed three monthly or sooner if a need is identified. Reviews were completed by the restraint coordinator. Any adverse outcomes were included in the restraint coordinators monthly reports and were reported at the monthly meetings. Restraint use is reviewed as part of the quality team meeting.</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)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Staffing has been adjusted in the dementia and psychogeriatric communities over the last three months to include an extra caregiver on duty during the morning and afternoon shifts. All staff working in the area confirmed that there are sufficient care staff in those communities on afternoon and morning shifts.</p> <p>There is a registered nurse and one caregiver rostered in the psychogeriatric and dementia communities (two communities operating as separate units) over night. There is a floating staff member in the upstairs hospital community who can provide support when required in the dementia and psychogeriatric communities. Staff stated that they call them to provide support if both staff do a round in one specific area or if there are residents up in the lounge area. At other times, both the registered nurse and the caregiver may leave one community to check or provide cares in the other community and staff stated that they do not always call for the floating staff member to come and relieve. Three staff who have completed night shifts in the past two months stated that they rely on the sensor mats to notify them of any residents who get up if they are in the next door community. Effectively, this leaves one community unattended at certain times</p>	<p>Staff do not always ring for the floating staff member to come to the community when they 'pop in' to complete checks or to provide two-person cares in a specific community (dementia or psychogeriatric).</p>	<p>Ensure that there is at least one staff on night shift in the dementia community and one in the psychogeriatric community at all times.</p> <p>60 days</p>

		<p>throughout the night.</p> <p>Staff also stated that if they are going to be in one community for a longer period of time than a quick check, then they do ring the floating staff for support. In an emergency the call bell is rung, and this is immediately responded to by the senior caregiver from the hospital wing (able to access the communities by internal stairs) and a registered nurse.</p> <p>The service is able to demonstrate that they have met the documented staffing levels according to the contract and to the Bupa staffing policy. The staffing levels currently however, do not cater for needs of residents who require two staff for cares or for residents who get up at night.</p>		
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Moderate</p>	<p>The service uses an electronic medication administration system, and three-monthly GP reviews and six-monthly resident reviews evidenced that the resident and family have been kept informed regarding medication management, however the administration of covert medications has not been documented according to Bupa policies.</p>	<p>Covert medication administration for two psychogeriatric residents, and one rest home resident did not have appropriate permission and discussion documented with family members and the GP or documentation in the care plan according to the Bupa policy.</p>	<p>Ensure that covert medication is only used according to Bupa policy.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent</p>	<p>PA Low</p>	<p>Families and resident all commented favourably of the care and support provided to residents. All residents had an individualised plan including a 'My day My way' 24-hour day planned based on the residents' previous schedule and desires. Staff were aware of resident needs and observation of staff demonstrated a caring approach to all residents. Neurological observation had not always been completed according to Bupa policy and weight loss management was not documented in one care plan.</p>	<p>Of nine unwitnessed falls six did not have neurological observations.</p> <p>One rest home resident did not have interventions to</p>	<p>Ensure that observations are documented according to Bupa policy.</p> <p>Ensure that</p>

with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.			manage weight loss documented.	care plans address all assessed needs. 90 days
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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.

No data to display

End of the report.