

Bupa Care Services NZ Limited - Bethesda Rest Home & Hospital

Introduction

This report records the results of a Partial Provisional Audit; 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: Bethesda Rest Home & Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 8 April 2019 End date: 9 April 2019

Proposed changes to current services (if any): A partial provisional audit was completed to assess the services preparedness for the opening of a 20 bed dementia unit by July 2019. The number of rest home beds will be reduced from 45 to 25. The total number of beds available remain at 91. Also verified were 20 of the 46 hospital beds as suitable as dual-purpose beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 68



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

Bupa Bethesda is certified to provide rest home and hospital level care for up to 91 residents. On the day of audit there were 68 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, a review of residents' and staff files, observations and interviews with residents, relatives, staff and management. The care home manager has been in the role for 17 years. She is supported by a clinical manager, who has been in the role for eight years.

This audit identified no areas for improvement.

The service has been awarded continued improvement ratings around the activity programme, food service and infection surveillance.

A partial provisional audit was also conducted to assess the preparedness of the service to provide dementia level of care. This audit verified there are appropriate processes being implemented for providing dementia level of care. Required improvements identified from this audit relate to environmental safety for residents around the kitchenette area, securing the area, and approval of fire evacuation procedure.

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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Bethesda endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents.

Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident; promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		All standards applicable to this service fully attained with some standards exceeded.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. A quality and risk management programme is being implemented. Quality activities generate improvements in practice and service

delivery. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A process for ongoing education and training for staff is documented and in the process of being implemented. The staffing levels meets contractual requirements. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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An admission package is available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner review.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for administration of medicines complete education and medication competencies. The medication charts reviewed met legislative requirements.

There is a daily rest home and hospital activity programme to meet the individual needs, preferences and abilities of the residents. The programme includes community visitors, outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for the residents.

All meals and baking are done on-site. Residents' food preferences and dietary requirements are identified at admission and accommodated. The menu is reviewed by the dietitian. Residents commented positively on meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. The hallways and communal areas are spacious and accessible. There is wheelchair access to all areas. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts. The service has an approved fire evacuation scheme. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. Appropriate training, information and equipment for responding to emergencies are provided. Housekeeping staff maintain a clean and tidy environment. Toilet/shower facilities are constructed for ease of cleaning. Cleaning services are well monitored through the internal auditing system. All laundry is completed off-site. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner.

The proposed dementia unit is not yet secure, all rooms are single. There is a lounge and dining area and safe access to a newly developed secure outdoor area.

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.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler or restraint, should this be required. The clinical manager is the restraint coordinator. Staff interviewed were knowledgeable about restraint minimisation. There were no restraints and one resident with an enabler.

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.
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Bethesda has an infection control programme that complies with current best practice. The infection control manual outlines a range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. There is a dedicated infection control coordinator who has a role description with clearly defined guidelines. The infection control programme is reviewed annually at organisational level.

The infection control programme is designed to link to the quality and risk management system. Infection control education is provided at orientation and incorporated into the annual training programme. Records of all infections are kept and provided to head office for benchmarking.

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	3	39	0	3	0	0	0
Criteria	3	85	0	5	0	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 (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in visible locations throughout the facility. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (seven caregivers, five registered nurses, one-unit coordinator, two activity coordinators, one kitchen manager/chef, one maintenance, the care home manager and clinical manager), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need</p>	FA	<p>There are established informed consent policies/procedures and resuscitation. General consents and specific consents where applicable were obtained on admission and sighted in the nine files reviewed (five rest home and four hospital residents). Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) were in resident files for residents deemed incompetent to make decisions.</p> <p>Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on.</p>

to make informed choices and give informed consent.		All long-term residents had a signed admission agreement and the short-term residents had a signed short-stay agreement.
<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>	FA	<p>Information about the national Health and Disability Advocacy service is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</p> <p>Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</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>	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. They have also created ongoing relationships with community groups that come to Bethesda. Resident and relative meetings are held bi-monthly.
<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 on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The care home manager maintains a record of all complaints, both verbal and written, by using the Riskman system. Seven complaints received in 2018 to date were reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up conversations and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the HDC. A complaint made through HDC in 2017 has been investigated and fully signed off. An HDC complaint in July 2018 did not meet their threshold, and was referred for the service to follow up. This has been fully investigated and signed off. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and unit coordinators discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Eight residents (five rest home and three hospital) and eight relatives (four rest home, four hospital) interviewed, reported that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.</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>	FA	<p>Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training.</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>	FA	<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. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. One resident who identified as Māori was living at the facility. Māori consultation is available through the documented iwi links and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6:</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with</p>

<p>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>		<p>the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's spiritual and cultural needs.</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>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions, and are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Registered nursing staff are available seven days a week, 24 hours a day. Two general practitioners (GP) visit the facility over two days a week. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The service receives support from the local district health board (DHB). Physiotherapy services are provided over ten hours a week, and a physiotherapy assistant is available four hours a day Monday to Friday. A podiatrist is on-site every six weeks. The service has links with the local community and encourages residents to remain independent.</p> <p>All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms online. These documents have been developed in line with current accepted best and/or evidence-based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy, alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms on Riskman (the electronic data collection software), have a section to indicate if next of kin have been informed (or not) of an accident/incident. Eleven incident forms were reviewed for March 2019 and all identified that family had been informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health 'Long-term Residential Care in a Rest Home or Hospital – what you need to know' is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they must pay for that are not covered by the agreement. Residents and relatives interviewed commented on feeling comfortable discussing issues with management, who have an 'open door' policy.</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>Bethesda is managed by a care home manager who is a registered nurse (RN). The care home manager has been in the role for 17 years. She is currently supported by a clinical manager who has been in the role for four years. The care home manager and clinical manager are supported by a Bupa regional manager and two unit coordinators (one of whom has been seconded to another Bupa facility temporarily). The care home manager has maintained at least 20 hours annually of professional development activities related to managing an aged care service. Bethesda is part of the Bupa group of care homes.</p> <p>The service currently provides care for up to 26 hospital (medical and geriatric) residents and 45 rest home residents. Twenty beds in the hospital have been verified as suitable to be used as dual purpose as part of this audit. At the time of the audit there were 68 residents. There were 26 hospital residents including one resident on a long-term support chronic health contract (LTS-CHC) and three residents on younger person with disabilities contract (YPD) contract. There were 42 rest home residents including one rest home resident on a YPD contract, one resident on respite care and two residents on a LTS-CHC contract. All other residents were under the Age Related Residential Care (ARRC) 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. Bethesda develops and implements quarterly quality reports on progress toward meeting quality goals, these are forwarded to Bupa continuous service improvements (CSI). The operations manager teleconferences weekly, visits monthly and completes a report to the director of care homes and rehabilitation. There were quality goals which also linked to the organisation's quality and health and safety goals.</p> <p>Staff spoke positively about the support/direction and management of the current management team.</p> <p>Partial provisional:</p>

		<p>A partial provisional audit was completed to assess the services preparedness for the opening of a 20-bed dementia unit in July 2019. The number of rest home beds will be reduced to 25. The total number of beds available remains at 91 beds.</p> <p>There is a transitional plan in place for the provision of dementia care services including discussion with the DHB regarding funding for dementia level of care, staffing, communicating changes with staff, residents, relative and the community. The transition plan has been submitted to the DHB.</p> <p>There are personnel at head office with expertise in aged care services, and the staff are currently completing training in dementia.</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>	FA	<p>Certification and Partial Provisional:</p> <p>During the temporary absence of the care home manager, the clinical manager or Bupa relieving facility manager covers the care home manager's role.</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</p>	FA	<p>Bupa has a comprehensive quality and risk programme documented for all Bupa services to implement. 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.</p> <p>The service has implemented monthly monitoring, collation and evaluation of quality and risk data which includes (but is not limited to): residents' falls; infection rates; complaints received; restraint use; pressure injuries; wounds; and medication errors.</p> <p>Quality and risk data, including trends in data and benchmarked results are documented as discussed in the quality and applicable staff meetings. The Bupa annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are developed when service shortfalls are identified and signed off when completed.</p>

<p>principles.</p>		<p>Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme.</p> <p>There was an annual resident/relative satisfaction survey completed in June 2018 with an overall satisfaction rate. Corrective actions were developed around food services and refurbishment of the building.</p> <p>Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes care plan interventions, sensor mats and use of low beds. The service implemented a goal around reducing falls in 2017 and 2018. In 2018, the number of falls had decreased by 28% in the hospital community. This was achieved by reinforcing falls strategies, implementing the use of hi/low beds, introducing extra fluid rounds, ensuring their belongings are close and residents have regular walks. Staff have received training around falls prevention, and have been provided with handouts with fall prevention strategies. Families have been provided with fall prevention information, and staff keep relatives informed of falls strategies in place, and meet with relatives to discuss interventions. Hip protectors are encouraged, and discussed with residents and relatives. Residents identified as 'frequent fallers' are monitored regularly. Non-medicine nursing interventions are used prior to administration of medications (eg, the use of wheat packs for pain). The GP is involved, and medications are reviewed with the aim to control symptoms, and reduce falls. One resident has been identified as high risk and has individualised falls strategies in place to include all of the above, and consideration to the dementia process. The resident has frequent monitoring, and reassurance provided. The activities staff have developed a scrap book for a distraction for this resident, and staff ensure a good supply of magazines are within reach to read. Activities, caregivers and RNs interviewed are aware of the falls strategies for residents and can fluently describe a range of these. At the end of 2018, the falls incidents had decreased from 107 in 2017 to 77 in 2018. The falls rate continues to decrease with 18 falls from January 2019 to date. Ten of these are one resident who has been requested for reassessment to a higher level of care.</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</p>	<p>FA</p>	<p>Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Eleven accident/incident forms were reviewed for the month of March 2019. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observations are conducted for all unwitnessed falls. Data collected on incident and accident forms are linked to the quality management system. The care home manager and clinical manager are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided.</p> <p>Policy and procedures are in place that includes definitions and outlines responsibilities including: immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Incident/accident data is linked to the organisation's data collection data base and is used for comparative purposes.</p>

<p>consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>There have been 22 major resident accidents in 2018 and four in 2019 to date. Incident reports have been fully completed, NOK have all been made aware, and have been included in care planning. Transfer to hospital and GP reviews have been appropriate and prompt. Fall prevention strategies have been implemented, interRAI reassessments have been completed as appropriate, and applications to NASC for higher level of care have been made when required.</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>	<p>CI</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Nine staff files (one clinical manager, unit coordinator, two RNs, three caregivers, one kitchen manager/chef and one activity person) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. Newly employed caregivers complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they will have attained their first national certificates. From this, they are then able to continue with Core Competencies Level 3 unit standards. These align with Bupa policy and procedures.</p> <p>There is an annual education and training schedule, that has been implemented for 2019. There are 12 registered nurses and two enrolled nurses. Nine registered nurses are interRAI trained. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). There are a number of implemented competencies for registered nurses including: insulin administration; moving & handling; nebuliser; oxygen administration; PEG tube care/feeds; restraint; wound management; syringe driver; and medication competencies.</p> <p>Partial provisional:</p> <p>There are nine caregivers who have completed the dementia specific unit standards and one caregiver progressing through the dementia units. Of the six caregivers on the proposed dementia care unit, five have completed dementia unit standards and one with level three is progressing through the dementia unit standards. There are caregivers allocated to the rest home with dementia care units that can provide cover for annual leave/sick leave. The clinical nurse leader has completed two of three days "leading the walk" dementia care training at the DHB. The DHB dementia coordinator is scheduled to provide training soon after the opening of the dementia unit. The service has a qualified DT to oversee the activity programme.</p>
<p>Standard 1.2.8:</p>	<p>FA</p>	<p>The staffing levels meet contractual requirements. The care home manager and clinical manager are available</p>

<p>Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>during weekdays. The care home manager is on call Monday to Thursday. The clinical manager and unit coordinators share the weekend call and public holidays.</p> <p>The Hospital wing staff for 26 residents includes two registered nurses (RNs) each shift plus:</p> <p>Caregivers AM: two 7.00 am to 3.00 pm; two 7.00 am to 2.00 pm; three 7.00 am to 1.00 pm.</p> <p>Caregivers PM: two 2.45 pm to 10.45 pm; two 4.00 pm to 9.00 pm.</p> <p>Night shift one caregiver and one or two RNs 11.00 pm to 7.00 am.</p> <p>The rest home wing 42 residents includes:</p> <p>Unit coordinator Monday to Friday 7.30 am to 4.00 pm. RN Sunday to Friday 6.45 am to 3.15 pm. Saturdays are covered with an EN week 1, and a senior caregiver week 2.</p> <p>Caregivers AM: Monday to Friday - one 6.45 am to 3.15 pm; one 7.00 am to 3.00 pm; one 7.30 am to 12.30 pm; one 7.00 am to 11.30 am. Weekends - one 6.45 am to 3.15 pm; one 7.00 am to 3.00 pm; one 7.00 am to 11.00 am; two 7.30 am to 12.30 pm; one 7.00 am to 12.00 noon.</p> <p>Caregivers PM: one senior caregiver Monday to Saturday/EN Sunday 3.15 pm to 11.15 pm; one 3.00 pm to 11.00 pm; and one 4.00 pm to 8.00 pm.</p> <p>Caregivers Night; two 11.00 pm to 7.00 am.</p> <p>Senior caregivers are medication competent.</p> <p>Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</p> <p>Partial provisional:</p> <p>A proposed roster for the dementia unit was reviewed.</p> <p>There are sufficient existing staff to accommodate the first five new admissions with an RN for seven days on morning shifts, and senior caregivers who are med competent covering afternoon and night with oversight from hospital registered nurse. The service plans to recruit new staff as admissions increase.</p> <p>The completed roster (full occupancy) will include;</p> <p>A unit coordinator (RN) Monday to Friday, and one RN will cover morning shifts over seven days a week.</p> <p>Caregivers AM; 2 x 7am-3pm, 1 x 7am – 1pm, and extra caregiver will be available to cover on the days there are GP rounds.</p> <p>Caregivers PM; 2 x 2.45pm -11.15pm (one will be a senior caregiver) 1 x 4.30pm-8.30pm.</p> <p>One senior caregiver will cover nightshift with support from the caregiver in the adjacent rest home unit, and</p>
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		oversight from the RN in the hospital unit.
<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 residents' 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. Residents' files are protected from unauthorised access by being held securely in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrate service integration with only medication charts held on an electronic system.</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>There are policies and procedures to safely guide service provision and entry to services, including a comprehensive admission policy. Admission information packs are provided for families/whānau and residents prior to admission or on entry to the service. Admission agreements in the files reviewed (for long-term residents) align with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer</p>	FA	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service. All relevant information is documented and communicated to the receiving health provider or service. A yellow envelope accompanies residents to receiving facilities and communication with family is made.</p>

from services.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>Policies and procedures are in place for safe medicine management that meet current guidelines and legislative requirements. There is a medication room in the hospital and a locked cupboard in the rest home nurses' office. All medications were securely and appropriately stored.</p> <p>Registered nurses and medication competent caregivers are assessed for competency annually. Registered nurses have completed syringe driver training.</p> <p>Medication charts have photo identification. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There is evidence of medication reconciliation on delivery of robotic roll medications by the RN.</p> <p>Staff sign for the administration of medications on medication sheets. This was documented and up-to-date on all 18 medication signing sheets reviewed. Electronic medication profiles reviewed were legible, up-to-date and reviewed at least three monthly by the GP. Where 'as needed' was prescribed the profile had an individualised indication for use. The medication fridge has temperatures recorded daily and these are within acceptable ranges. On the observed medication round, medication administration charts were signed as medication was administered.</p> <p>Staff were aware that residents who self-medicate require a safe place in their rooms to store medication and a current competency assessment to ensure their ability to self-medicate. Only one resident was assessed as competent to self-medicate at the time of the audit.</p> <p>Partial provisional:</p> <p>There is an established medicines management system in place. There are policies and procedures in place for safe medicine management that meet legislative requirements. The nurses' station will be the combined medication room and has keypad entry. The medication cupboards are lockable, the controlled drug safe is in place. There is a wash hand basin and a 'dirty' sink installed. There is an existing medication trolley that will be placed in the dementia unit. A medication fridge is yet to be installed.</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</p>	CI	<p>The facility has a large kitchen with a receiving area and food preparation area. Residents' food preferences are identified on admission. Kitchen staff are advised and updated with any changes to residents' dietary preferences, cultural needs, likes and dislikes. Alternatives are provided if a resident has specific dietary needs or would like an alternative to the main meal being served. The menus are seasonal and rotate on a four-weekly basis. The menu has been audited and approved by an external dietitian. There is a current food control plan in place which expires 22 September 2019. The chef advised that there are snacks available throughout the day including fruit, yoghurt, and ice-cream.</p> <p>Kitchen staff include a chef/supervisor, breakfast cook, and three kitchenhands. All kitchen staff have completed</p>

<p>service is a component of service delivery.</p>		<p>food safety education.</p> <p>Kitchen fridge, food and freezer temperatures are monitored and documented daily. Meals are transported to dining rooms and bain maries are used. Residents can have breakfast in their room. The dinner meal is cooked during the day and heated and probed at night prior to serving.</p> <p>Audits are completed throughout the year, these include: a kitchen audit, the kitchen environment, a catering service survey, and a food service audit. Internal audits are reviewed, and action plans implemented where required.</p> <p>Moulds are used to improve the presentation of pureed meals. Background noise has reduced, and quiet music is played during meal times. Staff were observed in the hospital wing assisting residents with their meals at the midday meal. Complimentary comments were received about the food service from many of the residents and family interviewed.</p> <p>Partial provisional:</p> <p>There is a small kitchenette area in the proposed dementia unit with a fridge for the provision of snacks and fluids 24 hours. The hot water tap is already in a cupboard which will be locked prior to occupancy (link 1.4.2.4). The meals will continue to be delivered to the dementia unit in a bain marie and served to the residents.</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>	<p>FA</p>	<p>If a potential resident is declined entry to the service, the reason is recorded and communicated to potential residents/family/whānau. If the service is unable to provide the assessed level of care or there are no beds available admission would be declined. If entry was declined the potential residents would be referred to the referring agency.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support</p>	<p>FA</p>	<p>There was evidence in files reviewed that the RN completes an initial admission assessment which includes relevant risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six-monthly, or earlier if there are changes to resident's health. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others. InterRAI initial assessments and assessment summaries were in place for the long-term resident files reviewed. Additional assessments for</p>

<p>requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>management of behaviour and wound care were appropriately completed according to need. The long-term care plans reflected the outcome of the assessments. The respite care resident had a short stay nursing assessment in place.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed were reflective of the outcomes of the interRAI and risk assessment tools completed. The care plans were comprehensive, resident-centred, and support needs were documented in detail. The care plans demonstrate service integration and input from allied health professionals involved in the care of the resident including GP, physiotherapist, podiatrist, dietitian, and the wound specialist nurse.</p> <p>Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process.</p> <p>Short-term care plans were in use for changes in health status to guide staff in the delivery of care for short-term needs. These were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan.</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>FA</p>	<p>When a resident's condition alters, the RN initiates a review and if required a GP visit. Communication to the GP for a residents' change in health status were sighted in the residents' files. Residents interviewed reported their needs were being met.</p> <p>The respite resident had a short-term care plan and all identified needs were addressed. Family members interviewed stated care and support is good and that they are involved in the care planning.</p> <p>Wound assessment, wound management plan and evaluation forms were in place for each wound, which document wound progression or deterioration. There were 22 wounds at Bethesda at the time of the audit including one stage two pressure injury. Wound documentation included the involvement of the wound nurse specialist where appropriate. Staff reported that they have all required equipment including pressure relieving equipment and wound care supplies. Access to specialist advice and support is available as needed. Care plans sampled documented allied health input.</p> <p>Contenance products are available (sighted) and resident files include urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>Monitoring charts were being used at Bethesda and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts, behaviour monitoring integrated with the care plans. All charts observed identified that required monitoring is occurring.</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>CI</p>	<p>An activities programme is provided for residents seven days a week. The programme is designed to reflect residents' interests. The programme is developed monthly and displayed in large print. Residents have a personal assessment completed after admission, which captures a resident's interests, career, and family background. This information is then used to design the lifestyle plan. A record is kept of individual resident's activities. Recreational progress notes for each resident is contained in the resident's file. The activity staff completes this for each resident every month. Each resident has a 'map of life'. The resident/family/whānau, as appropriate are involved in the development of the activity sections of the care plan. Long-term resident files reviewed identified review of the activity section of the care plan when the care plan is reviewed. One-to-one and group activities are provided to accommodate the needs of the younger residents. This includes supporting residents to access the community independently or with family and friends, taking the residents out for lunch, or out for coffees, to ensure needs are met.</p> <p>Families and residents interviewed reported an active life with a strong and enjoyable activities programme available.</p> <p>Bethesda employs one trained diversional therapist who works Monday to Friday. Two activities assistants job share Monday to Friday and another activities assistant works 10.00 am – 4.00 pm Saturday and Sunday.</p> <p>Partial provisional:</p> <p>Activities will be provided by the diversional therapist. Activities will be provided in the dementia unit from 1.00 pm to 5.30 pm over seven days a week. One activities assistant who works five days a week has completed training in 'person first for dementia care' through Bupa.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plans reviewed had been evaluated by registered nurses' six monthly, or when changes to care occurred. Short-term care plans reviewed for short-term needs were evaluated and either resolved or added to the long-term care plan. The care plan review involves the RN, GP, activities staff and resident/family. The family are invited to attend the care plan review or notified of the outcome of the review by phone call or email.</p> <p>There is evidence of a three-monthly or more frequent review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal</p>	<p>FA</p>	<p>Resident files sampled showed evidence of referral to other health and disability services. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>Policies and procedures provide documentation for exit, transfer or transition of residents. A yellow transfer</p>

<p>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>		<p>envelope is used when residents are transferring to hospital. There was evidence that families are kept informed in the event their family member is referred to another service. The clinical manager and registered nurses identified that the service has access to a wide range of support through the GP, specialists and contracted allied 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>	<p>FA</p>	<p>Policies and procedures guide staff in waste management, including general and medical waste to ensure incidents are reported in a timely manner. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas in all services. Material safety data sheets and product sheets are readily accessible for staff. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. The maintenance person described the safe management of hazardous material. Chemicals were correctly labelled and stored safely throughout the facility.</p> <p>Gloves, aprons and goggles were available, and staff were observed wearing personal protective clothing while carrying out their duties.</p> <p>The cleaners store chemicals in a caddy, which they take with them when cleaning. Staff have completed chemical safety training. A chemical spills kit is available. There are two sluice rooms with personal protective equipment available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>PA Low</p>	<p>The building holds a current warrant of fitness, which expires on 1 January 2020. Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. A 52-week planned maintenance programme is in place. Hot water temperature has been monitored regularly in all areas.</p> <p>The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. The corridors are wide with handrails. The external areas are well maintained and there is safe access to the outdoor areas. There is outdoor seating and shade.</p>

<p>for their purpose.</p>		<p>Caregivers interviewed stated they had adequate equipment for the safe delivery of care including two sling hoists, a standing hoist, platform weigh scales, air alternating pressure prevention mattresses, electric beds with high-pressure rating mattresses and lazy boy chairs on wheels.</p> <p>The facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate.</p> <p>As part of this audit, 20 of the 46 hospital beds were also verified as suitable as dual-purpose beds. There are sufficient lounge areas to ensure residents have different areas for group or individual activities.</p> <p>Partial Provisional:</p> <p>Since the previous audit, the service has refurbished one wing of the facility to enable provision of services to residents requiring dementia level care. There will be secure entry keypad access into the dementia care unit (not in place as the wing is currently occupied by rest home residents). The proposed unit has large resident rooms on the outer walls with a central 'service' block, housing the shared toilet and showers, the sluice room and nurses' station/medication room. Residents will have room to walk around the inside area freely. The open plan kitchenette, dining, and lounge area is bright and airy with an outside door to one of the secure outdoor areas. There are tea/coffee making facilities and the microwave is required to be made safe. The zip for hot water is currently in a cupboard which will be locked prior to occupancy. There is a separate quiet seating area beside one of the outside entries near the nurses' station.</p> <p>There is free access to the outdoor areas by three entry/exit doors to a secure outside/garden area with walking pathways, seating and shade sail are planned. The outdoor area has been renewed with the existing trees and planting removed, making way for new wide wavy paths and artificially grassed areas for seating. New plants and small trees have been planted. Borders are now narrower along the paved area outside the premium rooms. There are plans for water features and raised gardens for residents who enjoy gardening.</p> <p>The nurses station has two windows on either side of the station to allow staff to monitor residents.</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</p>	<p>FA</p>	<p>There are adequate toilets and showers in the rest home and hospital. The hospital and rest home have a mix of rooms with ensuite and shared communal bathrooms. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. 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. All bedrooms have a hand basin. In the hospital wing there are 14 ensuite rooms, six shared showers, and seven shared centrally located toilets. Commodes are available if needed. All rest home rooms have ensuites.</p> <p>Partial Provisional:</p> <p>There will be five premium rooms in the proposed dementia unit with ensuite toilet and shower. Fifteen rooms with shared facilities of two centrally placed showers, and four shared toilets. In the rest home wing there will be 25</p>

when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		rooms with ensuites.
<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 rooms are single and spacious. There is adequate space to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Hospital rooms have widened doors. Residents and families are encouraged to personalise their rooms. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments.</p> <p>Partial provisional:</p> <p>The resident rooms in the proposed dementia care unit are all single and are spacious enough for residents to move about freely with the use of mobility aids if required. The five premium rooms are large with a small kitchenette area with a fridge. The jug/kettle will be kept out of reach of the residents when not in use. These rooms have ensuites, and have outdoor access onto a paved garden area.</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>There are several lounges throughout the facility and combined lounge/dining rooms in the rest home and hospital with panoramic views of the outdoor area. Residents and staff can move freely around the facility. Activities occur throughout the facility.</p> <p>The hospital unit is made up of communities/areas with their own lounge area. There is a large central open plan lounge dining room with kitchenette area with bain marie, fridge, and dishwasher.</p> <p>Smaller lounge dining area with kitchenette half way through the hospital unit, and smaller designated lounge at the other end of the unit, and small cosy seating areas.</p> <p>Partial Provisional:</p> <p>The proposed dementia unit is not yet secure within the existing structure. The open plan kitchenette, dining, and lounge area is bright and airy with an outside door to one of the secure outdoor areas. There are tea/coffee making facilities (link 1.4.2.4). There is a quiet seating area close to the nurses' station.</p>
Standard 1.4.6: Cleaning And Laundry Services	FA	Laundry has been outsourced and dirty linen is collected daily, and clean linen returned daily. The laundry has a clean/dirty flow and chemicals are stored securely. Cleaning and laundry services are monitored through the internal auditing system. Cleaning rooms are locked when not in use.

<p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>Staff receive training at orientation and through the in-service programme. The cleaning and laundry staff have completed chemical training.</p> <p>Laundry service satisfaction is included in the annual survey. Residents and relatives reported satisfaction with the laundry services.</p> <p>Partial provisional:</p> <p>New covered linen trolleys have been purchased, there is a locked sluice room in the dementia wing (total three) for the facility. There will be a designated cleaner in the dementia unit. Laundry services will remain the same.</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>	<p>PA Low</p>	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available and regularly checked. The kitchen has power and gas cooking and there is a gas barbeque and gas bottles available. There is sufficient water and food stored on-site for at least three days in the event of an emergency. There is a two-hour battery backup for emergency lighting and a generator is provided as a priority through Bupa as required.</p> <p>There is an approved fire evacuation scheme in place for the facility. There are six monthly fire drills. Fire safety is completed with new staff as part of the health and safety induction and is ongoing as part of the education plan. There is a first aider on duty at all times.</p> <p>Resident's rooms, communal bathrooms and living areas all have call bells which when activated, are displayed on corridor lights that are easily visible. Security policies and procedures are documented and implemented by staff who conduct security checks of the building on afternoon and night shift. The buildings are secure at night with afterhours doorbell access, which is connected to the call bell system. Fire exit doors are linked to the fire alarms.</p> <p>Partial provisional:</p> <p>There has been no alteration to the number of beds within the facility. With the addition of the new dementia wing, there will be an additional fire door installed. The existing call system is operating in the proposed dementia care unit. The fire evacuation procedure is the process of being updated and will need approved by the fire service and a fire drill will be completed for the new wing.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The residents and family interviewed confirmed the temperature of the facility is comfortable. There are large bay windows in all of the lounge areas which flood the facility with natural light. Heaters in resident rooms are now installed on the ceiling in the refurbished rooms including the dementia unit.</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</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>	<p>FA</p>	<p>Bethesda has an infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system and the Bupa KPIs. A unit coordinator is the designated infection control nurse and has access to the DHB infection control nurse and microbiologist. Audits have been conducted and include hand hygiene, infection control practices in the laundry and cleaning service. Education is provided for all new staff on orientation. Staff interviewed stated they had adequate supplies of personal protective equipment (PPE). The infection control programme is reviewed annually by the Bupa North and South Island infection control teams (made up of IC coordinators from across Bupa).</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.</p> <p>There was an outbreak of norovirus in February 2019 which was well managed. Staff were updated on a daily basis and comprehensive records were maintained. Appropriate notifications were made in a timely manner. A debrief was held with the infection control nurse from the DHB.</p> <p>Partial Provisional:</p> <p>The infection control coordinator will continue to oversee infection control for the facility including the dementia care unit. The programme remains appropriate to the size and scope of the service provided.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources</p>	<p>FA</p>	<p>The infection control coordinator has a graduate certificate in infection control, completes online infection control courses, and has been invited to a DHB study day later in 2019. Infection control is part of the combined committee which covers quality and health and safety. The infection control coordinator has access to the Bupa infection control officer, DHB infection control, public health nurses, and regularly checks the WHO (world health organisation) regulations.</p>

<p>to implement the infection control programme and meet the needs of 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>	<p>FA</p>	<p>The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection control policies link to other documentation and uses references where appropriate.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator ensures training is provided to staff. Informal education is provided at handovers when an issue has been identified. Availability of the education was confirmed by caregivers interviewed. The orientation package includes specific training around hand washing and standard precautions. Training on infection control occurred in April 2019. Hand washing is an annual competency. Resident education is expected to occur as part of providing daily cares.</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 and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and local laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.</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 restraint policy in place with a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The process of assessment and evaluation of enabler use is the same as a restraint and included in the policy. The service had no bedrails in use and one lap-belt as an enabler in use. The file sampled for the resident with a lap-belt as an enabler demonstrated that enabler use is voluntary. The service has limited restraint use over recent years and is currently restraint free. Training has been provided around restraint and enablers on an annual basis.</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 1.3.12.1</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>	PA Low	There is a keypad entry to the nurses' station where the medications will be held. There is adequate locked cupboard space for storage of medications. The controlled drug safe has been installed. There is provision for computers to be installed and a tablet for medications prior to occupancy.	Partial Provisional: The medication fridge is not yet installed.	<p>Ensure a medication fridge is installed prior to occupancy.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	All equipment is in place and has been calibrated. Hot water temperatures have been checked and are within range. There is a current building warrant of fitness in place for the facility.	Partial Provisional: A secure fire door is to be installed that links to the alarm system.	Ensure the new key padded fire door is reviewed and approved as part of the warrant of fitness

				Prior to occupancy days
<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	The resident rooms are spacious with shared toilet and shower facilities nearby. The indoor area is spacious for residents to wander freely with 'dead end' areas camouflaged. There is safe access to all secure outdoor areas which are spacious and secure. The security fence includes rails with three gates at the end of each area. All gates have keypad security, which will be used in the event of emergencies only. All equipment is in place and has been calibrated.	Partial Provisional: (i) The proposed area is not yet secure. (ii) The cupboard holding the hot water zip is not locked. (iii) Outdoor furniture and shade sail are yet to be installed.	<p>(i). Ensure the unit is secure and keypads have been activated.</p> <p>(ii) Ensure the hot water zip is in a locked cupboard, and (iii) outdoor furniture is in place.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Low	Appropriate training, information, and equipment for responding to emergencies is provided as part of the annual training programme. A fire drill in the new unit dementia unit is to be completed.	Partial Provisional: As the unit is not yet secure, a fire drill is yet to be completed.	<p>Ensure a fire drill of the wing has been completed.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	There is a current fire evacuation scheme that is approved by the fire service. With the adjustments to the new unit, a new fire door is being installed. The evacuation point for the dementia unit is being adjusted. The fire evacuation procedure is the process of being updated and will need approved by the fire service.	Partial Provisional: The fire evacuation procedure is the process of being updated and will need to be approved by the fire service	<p>Ensure the fire evacuation scheme is amended and approved by the fire service</p> <p>Prior to</p>

				occupancy 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<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 consumers.</p>	CI	<p>Education is a key focus at Bethesda, with quality goals including having all staff complete Careerforce dementia training, and having all qualified staff achieve PDRP in 2019. There was an extensive education plan that was being achieved in 2018, with an equally extensive plan for 2019, which has been implemented. Completion of courses is celebrated, and certificates are placed on a wall in the facility. Currently there are 13 caregivers with level 4 Careerforce, nine at level 3, and there is another one in the process of completing this. Nineteen caregivers have level two. In preparation to opening the dementia unit, and to increase the knowledge of the care staff in dealing with residents diagnosed with dementia, eight caregivers have completed Careerforce level 3 Residential (Dementia series) and one caregiver is in training. Bethesda have enrolled 15 caregivers in December 2018, to do the same course. A designated day has been assigned for care staff to get together in a group with the clinical manager and discuss the workbook that they need to complete. Three staff (including the care home manager) have attended “Person First</p>	<p>Since completing the education, the management team have noted the caregivers are more proactive in using de-escalating techniques. When a resident is restless, caregivers now go through the process of eliminating the cause of restlessness, from needing to use the toilet, food and fluid requirements, pain assessment and boredom or too much background noise, staff were observed talking with anxious and restless residents. Caregiver and activity staff have made a scrapbook for one of the residents, who is currently waiting for re-assessment level of care to help settle them down when they are restless and agitated. The staff refer to the scrapbook or the photo album when talking to this resident. The clinical manager has observed staff appear to have more understanding and patience towards those residents with dementia, rather</p>

		<p>Dementia Second” education, and are in the process of completing the course. Once they complete the course, they will hold a session for the facility staff to share their knowledge.</p>	<p>than resorting to administering antipsychotic medications. The review of the medication charts evidences a very low usage of antipsychotic medications.</p>
<p>Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>CI</p>	<p>As part of the Bupa Coaching Programme staff reviewed recent resident satisfaction data. A satisfaction survey in 2018, rated the dining experience at 75%, Bethesda staff chose to look at improving the dining experience for residents as a quality improvement initiative.</p> <p>It was identified that the food was often not hot at tea time, pureed meals were not appetising, and the background noise was very loud during meal times. To ensure the meals were served hot the bain marie element was replaced, a new bain marie and thermo plate warmer were purchased.</p> <p>Residents having pureed meals were unable to eat some of the food offered during special occasions; and it was noted improvement could be made to presentation of this food. Bethesda introduced food moulds; cooks use the moulds to improve presentation of food for those on pureed diets. The cook trialled putting the pureed meal in a mould and freezing it. The food was then put it in the steamer to thaw and served to the residents in a moulded form, in the shape of carrots, bread, cabbage, pumpkin, peas, sausage and beetroot shapes. The food is served to residents, with a jug of gravy. Residents are now able to enjoy food served on special occasions and the food during lunchtimes is more appealing. The residents, their families and the dietitian liked this presentation option and so Bethesda continue to offer the moulded pureed food to the residents. The improvement was discussed during quality and RN meetings and shared in the resident’s newsletter in 2018.</p> <p>The background noise was reduced by discontinuing use of the dishwasher and food mixer between 12.00 pm – 12.30 pm and 5.00 pm – 5.30 pm and background music is now played at meal times to enhance ambience.</p>	<p>As part of the Bupa Coaching Programme staff reviewed recent resident satisfaction data. A satisfaction survey in 2018, rated the dining experience at 75%, Bethesda staff chose to look at improving the dining experience for residents as a quality improvement initiative. Strategies were implemented and evaluated for effectiveness. A satisfaction survey conducted in April 2019 showed 84% satisfaction for meals and 94% of residents surveyed stated the background noise was acceptable to them.</p>

		Staff were also observed in the hospital wing assisting residents with their meals at the midday meal. Bethesda staff are continuing to encourage residents to contribute ideas on how improvements can be made to the residents dining experience.	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service was keen to provide a greater emphasis on special events. A calendar of monthly special events was developed. Golden Globe Awards included an award ceremony with decorations where residents were recognised for their participation and achievement in activities within the facility. Valentine’s Day was celebrated and included decorations and an entertainer singing love songs. St Patricks Day included decorations, green food and community involvement with Irish dancers who entertained the residents.</p> <p>To accommodate the increased number of residents with cognitive impairment and dementia a more holistic approach to activities to better cater to all levels of resident ability was devised. A picture housie was developed to enable residents with dementia to more easily identify pictures rather than number combinations. A larger print for vision impaired residents is also in use. Quizzes using famous faces are now simpler and can be interchanged from one level of complexity to another depending on the diversification of the residents participating. This has been trialled for the last two months with hospital and rest home residents</p>	<p>The service introduced a quality initiative around accommodating an increased number of residents with cognitive impairment. The housie and quizzes have been adapted to cater for all levels of resident ability. The level of difficulty can be adjusted depending on the residents’ ability. Picture housie rather than number housie and larger print for vision impaired residents has been developed. Group participation for quizzes, word-building and housie has increased from 10-15 per session to more than 20 participants per session. The sessions are now reported to be more interactive. Resident feedback included comments that the activities are easier to see, more people participate, and the new format was more enjoyable.</p>

End of the report.