

Bupa Care Services NZ Limited - ParkHaven 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: ParkHaven Hospital

Services audited: Residential disability services - Intellectual; Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Mental health services; Hospital services - Geriatric services (excl. psychogeriatric); Residential disability services - Physical; Residential disability services – Sensory

Dates of audit: Start date: 5 June 2019 End date: 6 June 2019

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 80



Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Parkhaven Hospital is part of the Bupa group. The service is certified to provide hospital (medical and geriatric), mental health hospital, psychogeriatric and residential disability (intellectual, physical and sensory) level care for up to 84 residents. On the day of the audit, there were 80 residents.

A care home manager who is appropriately qualified and experienced, manages Parkhaven. Feedback from residents and relatives is positive about the care and services provided. An induction and in-service training programme is provided.

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

This certification audit identified one improvement required around dementia staff training.

The service is commended for achieving a continuous improvement rating around food service.

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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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 celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. Family/whānau participation meetings are held every two months. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical nurse manager are responsible for the day-to-day operations of the facility. The quality and risk management programme includes a service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. There are regular resident/family meetings. An annual resident/relative satisfaction survey is completed. Health and safety policies, systems and processes are

implemented to manage risk. Incidents and accidents are reported and followed through. An annual education and training programme is in place. Appropriate employment processes are adhered to. Staffing is flexible to meet the needs of the residents. Registered nursing cover is provided 24 hours a day, seven 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.

All standards applicable to this service fully attained with some standards exceeded.

There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans reviewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered and enrolled nurses are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP. The activities coordinator, with the assistance of the activities assistants implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. All meals are cooked on site. Residents' food preferences, dislikes, religious and cultural dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

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.

Documented systems are in place for essential, emergency and security services. Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. All rooms have hand basins, some rooms have a toilet, and some rooms share a toilet. The other resident rooms share communal toilet/showers. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. External areas are safe and well maintained with shade and seating available. The psychogeriatric and mental health garden is safely fenced. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security service. The building has a current warrant of fitness and was observed to be appropriate and suitable to the needs of the residents, with appropriate heating and ventilation.

Restraint minimisation and safe practice

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

Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. Training around restraint and enabler use has been provided to staff. At the time of the audit, there were 11 residents using 14 restraints and seven residents with eight enablers. Restraint management processes are adhered to.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	51	0	1	0	0	0
Criteria	1	124	0	1	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with 16 care staff; including seven caregivers, six registered nurses (RN) including one-unit coordinator from the hospital and one-unit coordinator from the psychogeriatric and mental health units, one enrolled nurse (EN) and two activities reflected their understanding of the key principles of the Code. Staff receive training about the Code which was last completed in April 2018.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (five hospital including one young person with a disability and one ACC, and two psychogeriatric including one long-term chronic care support). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. In the psychogeriatric unit all residents had activated EPOAs. Three EPOAs were held by the Public Trust.

<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 on advocacy services through the HDC office is included in the resident information pack provided to residents and family on admission. Pamphlets on advocacy services are available at the entrance to the facility and located around 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	<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 and providing assistance to ensure they are able to participate in as much as they can safely and desire to do. This includes resident's visits to the local mall, visiting the library and attending community celebrations. Resident/family meetings are held regularly and there are two monthly family participation groups in the mental health unit. All residents, especially younger residents, are provided with opportunities to engage in the community and younger residents are encouraged in these activities as they are able.</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>The organisation has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaints' register in Riskman where verbal and written complaints are documented. All complaints have noted investigation, timelines, corrective actions when required and resolutions. Complaints are linked to the quality and risk management programme. Seven complaints were made in 2018 and five complaints were received in 2019 year to date. All complaints have noted investigation, timelines, corrective actions when required and resolutions. Complaints are linked to the quality and risk management programme. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</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 RNs discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Seven residents (six hospital including, one younger person and one mental health) and five relatives interviewed (three hospital, one psychogeriatric and two mental health) 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 and</p>

		residential disability level care.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	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, which was last completed in July 2018. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	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. During this audit there were five Māori residents living at the facility. Cultural needs were identified in care plans reviewed for two of the residents. 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, last completed in June 2019. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. A day has been planned for the end of June 2019 to celebrate Matariki with Māori related activity including a Māori quiz, activities, arts and crafts and a hangi lunch.
Standard 1.1.5: Recognition Of Pacific Values And Beliefs Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Pacific residents are valued and fostered within the service. They value and encourage active participation and input of the family in the day-to-day care of the resident. There are a significant number of residents identified as Pacific living at the facility. There are also a number staff who identify as Pacific and all Pacific languages are spoken by staff. All caregivers interviewed were aware of the importance of the relationships between the Pacific consumer, their family and their community in the delivery of care for Pacific residents. At the time of the audit the service celebrated Pacific (Samoa) cultural day, activities included a Pacific quiz, entertainment, arts and a traditional Samoan lunch.
Standard 1.1.6: Recognition	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved

<p>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>with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All 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. A cultural day celebrating different cultures represented at the facility is held monthly. All care plans reviewed included the resident's social, spiritual, cultural and recreational 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. Interviews with caregivers confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. Professional boundaries 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 two caregivers from the psychogeriatric and mental health unit could describe how they build a supportive relationship with each resident. Interviews with families from the psychogeriatric and mental health unit confirmed the staff assist to relieve anxiety.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. There are clear ethical and professional standards and boundaries within job descriptions. Registered nursing staff are available 24 hours a day, seven days a week. A GP visits the facility twice a week and an afterhours GP service is in place. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is deemed not stable. Residents in the mental health unit and psychogeriatric unit are reviewed by the psychogeriatrician regularly. Physiotherapy services are provided on site daily, for two hours, and a dietitian is available as required. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent. The GP interviewed is satisfied with the level of care provided. Residents and relatives interviewed spoke positively about the care and support provided.</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 family/whānau is recorded on the family/whānau communication record, which is held in resident files.</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Seventeen accident/incident forms reviewed identified that family are kept informed. Relatives interviewed confirmed that they are kept informed when their family member's health status changes.</p> <p>There are a number of residents (and staff) from a variety of cultures, and family interviewed were particularly complimentary of how staff are able to communicate with residents where English is a second language. 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.</p> <p>There is a specific 'Introduction to the psychogeriatric unit' booklet providing information for family, friends and visitors to the facility included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families.</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>Parkhaven is part of the Bupa group. The service is certified to provide hospital (medical and geriatric), mental health hospital, psychogeriatric and residential disability (intellectual, physical and sensory) level of care for up to 84 residents.</p> <p>On the day of the audit there were 80 residents living at the facility. Forty-eight residents in the hospital wing included six residents on a young persons with disability (YPD) contract, three residents on a long-term support chronic health conditions (LTS-CHC) contract and two residents funded by ACC. There were 10 residents in the mental health (MH) unit and 22 residents in the psychogeriatric (PG) unit, which included one resident on a LTS-CHC contract. There were no residents at an intellectual or sensory disability level of care. All other residents were on the age related residential care (ARRC) contract. At the time of the audit there were twelve residents enrolled in the day care programme, which is run by the activities staff (not reviewed as part of this audit).</p> <p>There is an overall Bupa business plan and risk management plan. Parkhaven has identified specific and measurable quality goals for 2019 in their annual quality plan. Progress reports are reported quarterly on goal achievement.</p> <p>The care home manager (non-clinical) is an experienced care home manager with over 20 years' experience. She has been managing Bupa Parkhaven for one year. A clinical manager and a Bupa operations manager support her. The clinical manager has ten years' experience as an RN and has been in the position for two years. She is supported by two-unit coordinators.</p> <p>The care home manager and clinical manager have undertaken a minimum of eight hours of professional</p>

		development over the past 12 months relating to the management of an aged care service.
Standard 1.2.2: Service Management 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.	FA	In the absence of the care home manager, the clinical manager is in charge, with support from the operations manager. In the absence of the clinical manager, the two-unit coordinators are in charge.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	<p>Bupa has an established quality and risk management programme. Quality and risk performance is reported across facility meetings and to the Bupa regional manager. The quality programme includes an annual internal audit schedule. Audit summaries and action plans are completed where a noncompliance is identified. Action plans have been implemented and closed out. Meeting minutes documented that results of audits are communicated to staff. The service collects information on resident incidents and accidents as well as staff incidents/accidents. Incident and accident data results are documented as discussed in staff meetings, quality and RN meetings. Meeting minutes are maintained, and staff are expected to read the minutes and sign off when read. Resident/relative meetings are held bi-monthly.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. Policies are regularly reviewed and new policies or changes to policy are communicated to staff. An annual relative/resident satisfaction survey was completed in September 2018. Corrective actions were established in areas identified for improvements around dining experience, home renovations and garden improvements. Surveys include young people with disabilities around issues relevant to this group.</p> <p>One health and safety committee chair (care home manager) was interviewed about the health and safety programme. The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. The health and safety committee team meet bi-monthly. Staff undergo annual health and safety training which begins during their orientation. An up-to-date hazard register is in place and was last reviewed on 13 February 2019. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats and chair alarms. Staff are kept informed of residents at risk of falling.</p>

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	<p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. All incidents are coded in severity on Riskman (severity 1-4) with 4 being the most severe. All resident incidents logged with a severity of 3 or 4 are automatically escalated to the Bupa CSI team immediately and the operations manager. Actions are then followed-up and managed. Twelve accident/incident forms were reviewed for April 2019. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observation forms were documented and completed for eight unwitnessed falls or falls with a potential head injury.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been seven section 31 notifications made since the last audit relating to four unstageable and one stage three pressure injuries and two resident absconding incidents (police involved) since the last audit.</p>
Standard 1.2.5: Consumer Participation Consumers are involved in the planning, implementation, and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.	FA	<p>There is a consumer participation policy (mental health unit) detailing the requirement for staff to work in partnership with consumers to develop and review care plans. The admission agreement also encourages residents to ask questions about their care plan. Many of the residents in the mental health unit have dementia and are unable to participate in the care planning process.</p> <p>In these instances, interview with family, staff and resident file review confirmed family/whānau are encouraged to participate in the development and review of resident care plans. Resident nominated advocates (caregivers) are also available to support the care planning process if required. The service holds resident committee meetings. This is a recent initiative. Meetings are chaired by residents and provide opportunity for residents to provide feedback on services provided as well as input into service development activities. Recent feedback from residents has included requests for more activities/outings on the weekend. Resident satisfaction surveys are completed. Staff advised family will be asked to complete satisfaction surveys if the resident is unable to due to cognitive impairment. Code of Rights training is compulsory for all staff, and person-centred care planning is a core induction training module for all staff.</p>
Standard 1.2.6: Family/Whānau Participation Family/whānau of choice are involved in the planning, implementation, and	FA	<p>There is a service family/whānau participation and contact policy detailing processes to promote and seek family/whānau input into care planning and provision. The policy specifically includes requirements for family to be consulted throughout treatment and recovery processes for mental health residents, and provision of support to enable families/whānau to obtain information/education and access advocacy services. Family participation meetings are a new service initiative occurring every two months. Staff interview, resident files and service meeting minutes confirmed family participation meetings are held. Meeting minutes evidence</p>

evaluation of the service to ensure services are responsive to the needs of individuals.		family/whānau have utilised the forum to raise service delivery issues/concerns, suggest changes to how services are being delivered and/or provide feedback on the quality of services being delivered to their family/whānau member. The service does not have a dedicated family/whānau advisor.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	<p>There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Ten staff files were reviewed (one clinical manager, one-unit coordinator, two RNs, five caregivers and an activities coordinator). All files contained relevant employment documentation including employment contracts, job descriptions and completed orientations. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of elderly care. Staff interviewed believed new staff are adequately orientated to the service on employment. There is an annual education and training schedule being implemented which exceeds eight hours annually for each staff member. Opportunistic education is provided via toolbox talks. Competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). Staff had a wellbeing training session covering mental health illnesses and issues, e.g. bipolar disorder. A toolbox talk was provided to care staff following this training. Regular training occurs around managing behaviours and de-escalation techniques.</p> <p>Seven of the twelve RNs (including the clinical manager and two-unit coordinators) have completed interRAI training. Seventy nine percent of the total staff have attained at least one Bupa Personal Best certificate. A total of 80% of caregivers have attained a national certificate qualification. Twenty-one caregivers are rostered to work in the garden wing (psychogeriatric and mental health unit). Two caregivers who have been employed for over 18 months have not completed the required dementia standards. The nursing staff attend external training provided by the organisation and the DHB. The clinical manager reports that there are a range of in-services provided annually in relation to residential disability services including (but not limited to) suicide prevention, sexuality and intimacy, cultural competency (one YPD resident identifies as Māori), and advanced nursing practice. Staff training has included sessions on privacy/dignity and spirituality/counselling to ensure the needs of younger residents are met.</p>
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or	FA	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a care home manager and clinical manager who work full time from Monday to Friday. The clinical manager is supported by two-unit coordinators (one hospital wing and one across the psychogeriatric (PG) and mental health (MH) in the garden wing). The care home manager, clinical manager and unit coordinators share the on-call duties on a weekly basis.</p> <p>In the hospital unit there were 48 of 50 residents, there are two RNs on duty on the morning and afternoon</p>

experienced service providers.		<p>shifts and one RN on the night and weekend shifts. In the garden wing there were 22 of 22 PG residents and 10 of 12 MH residents, there is one RN on duty on the morning and afternoon shifts, and one on the night shift.</p> <p>There are adequate numbers of caregivers rostered. In the hospital wing there are nine caregivers on duty on the morning shift (five long/four short shifts), five caregivers on duty on the afternoon shift (four long/one short shifts), and three caregivers on the night shift.</p> <p>In the garden unit (PG and MH units) there six caregivers on duty on the morning shift (five long/one short shifts), five caregivers on duty on the afternoon shift (three long/two short shifts), and two caregivers on the night shift. Extra staff can be called on for increased resident requirements. Activities staff are rostered for the care home and the day care programme. Interviews with residents and family members identified that staffing is adequate to meet the needs of residents. Staff interviewed stated that there was sufficient staff on duty and that they felt supported by the management team.</p>
<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. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant carer. Residents' files demonstrate service integration.</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 an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC and the ARHSS contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</p> <p>Resident files and staff interview confirmed all referrals to the service are via CMDHB. On receipt of a referral, the care manager and community liaison officer review the referral information and identify the level of resident need and risk. If more information is required, the community liaison officer will meet with the resident (and family/whānau as appropriate) as well as referring service staff. Those with higher needs and/or risks are routinely prioritised.</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>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the CMDHB 'yellow envelope' transfer system. Communication with family is made.</p>
<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>	FA	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. All policies and procedures had been adhered to. There are standing orders, and these meet legal requirements. There were no vaccines stored on site. The facility uses an electronic medication system and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and enrolled nurses administer medications. All staff have up-to-date medication competencies and there has been medication education this year. Registered nurses have syringe driver training completed by the hospice.</p> <p>The medication fridge temperature is checked daily. Eye drops are dated once opened. Staff sign for the administration of medications on medication sheets. Eighteen medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed. Resident files and staff interview evidenced residents are regularly reviewed by the service GP and the CMDHB mental health for older persons team (mental health unit residents only) to support continuity of care and monitor and maintain resident wellbeing.</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>	CI	<p>All meals at Bupa Parkhaven are prepared and cooked on site. There is a six-weekly seasonal menu which has been reviewed by a dietitian. Meals are delivered in scan boxes to each unit dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed and diabetic meals are provided. Cultural and religious food preferences are met. Staff were observed assisting residents with their meals and drinks in the psychogeriatric unit and hospital. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally.</p> <p>Residents and family members interviewed, were satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded on each meal. The dishwasher is checked regularly by the chemical supplier. There is evidence that there is additional nutritious snacks available over 24 hours. All food services staff have completed training in food safety and hygiene and chemical safety. Recently the facility</p>

		has initiated an enhanced dining experience project.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident where possible and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled, including YPD, ACC and LTS-CHC. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but are not limited to) nutrition, continence, culture, pain and behaviour. Assessment of cultural need occurs at service entry and every six months (or more frequently if required) as part of the regular review of individual care plans. Appropriate cultural support is accessed if identified as a resident need.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provide detail to guide care. YPD care plans take into account age related activities and promote independence. Short-term care plans are in use for changes in health status. Residents and relatives interviewed, stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the dietitian, wound care nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow. Early warning signs and associated interventions to mitigate are identified in the resident's care plan. Care plans are developed in collaboration with the resident (if able) and family/whānau (as appropriate).
Standard 1.3.6: Service Delivery/Interventions	FA	When a resident's condition changes, the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. All care

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Care staff interviewed stated that they found the care plans very useful and a guide for care needed. Resident falls are reported electronically and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their head. Family are notified. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are documented, and wound monitoring occurs as planned. There are currently eight wounds and one skin condition being treated (including the pressure injury). The non-facility acquired pressure injury was stage 3 on admission but is now stage 2. There are photos of the healing process and the resident is on Beneprotein to assist healing. Pressure injury prevention equipment is available and is being used. Caregivers document changes of position on a turning chart. Monitoring forms are in use as applicable such as weight, vital signs, wounds and behaviour.</p> <p>The mental health unit is locked. Residents have access to a large lounge area, smaller dining area and a space to relax on couches adjacent to the lounge. There is access to the outside garden area. Individual care plans are inclusive of goals focused on physical health and wellbeing.</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>There is one activities coordinator working 8.00 am to 4.00 pm Monday to Friday and she supervises all areas. There are three activities assistants working 8.00 am to 4.00 pm Monday to Friday, one in the hospital, one in the psychogeriatric and mental health area and one covers day care. The activities coordinator is completing the diversional therapy course. On the days of the audit residents were observed doing exercises, listening to music and dancing, having a van outing, taking part in a quiz, and taking part in a Samoan cultural day. The latter included music, dance, costumes and food. There is a weekly programme in large print on noticeboards. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. The hospital and day care combine for some activities, as do the psychogeriatric and mental health units.</p> <p>There is a sensory group for those who are cognitively impaired. Residents are encouraged to taste, smell, and feel. Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat. There is an interdenominational church service monthly and a Tongan pastor holds a weekly prayer meeting. Catholic volunteers come in to give communion. There are van outings twice weekly and this includes the psychogeriatric unit. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Father's Day, Anzac Day and the Melbourne Cup are celebrated. Recently they held a high tea for Queen's birthday. There is pet therapy monthly, one staff member brings in her puppy and one family brings in their poodle.</p> <p>There is community input from pre-schools, schools, church groups and cultural groups including kapa haka. Residents go out to the RSA, the Cosi club, stroke club and an art gallery group. Residents have an activity</p>

		<p>assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident/family meetings are held two monthly. Residents and family members interviewed stated that they were satisfied with the activities provided. The YPD residents interviewed were satisfied with activities. They stated that they are encouraged to pursue hobbies and go out into the community.</p> <p>Activities meet the abilities of resident groups including a programme for younger people.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Eight care plans reviewed had been evaluated by the RNs six monthly or when changes to care occurs. The other care plan was for a resident who was a relatively new admission. Short- term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the clinical manager RN, activities coordinator and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan. Evaluation of progress toward care plan goals occurs in collaboration the with resident (if able), the family/whānau (if appropriate and available), the service GP and the CMDHB mental health for older persons clinical staff.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the dietitian, and mental health services for older people. Discussion with the RN identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and	FA	There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols.

service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		Gloves, aprons, and goggles are available for staff.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>The building holds a current warrant of fitness which expires 16 March 2020. There is a maintenance person who works full time five days a week. There is a contracted gardener. A contracted plumber and electrician are available when required. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, and hallways are carpeted in the hospital and there is vinyl in the psychogeriatric and mental health unit.</p> <p>The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is a large fenced-off garden off the psychogeriatric and mental health units. All outdoor areas have seating and shade. There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver care for hospital, psychogeriatric and mental health level of care residents.</p>
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	All rooms have hand basins. Seven rooms have their own toilet and eight rooms share a toilet. All other rooms use a communal toilet and all showers are communal. There are adequate numbers of both. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and hoists if appropriate. There are signs on all shower/toilet doors.
Standard 1.4.4: Personal	FA	There are 38 single rooms and 23 double rooms. All single rooms in PG and MH units. The double rooms are in hospital. Consent has been given to share and there are curtains for privacy. There is sufficient space

Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are large and also smaller communal areas in the hospital, psychogeriatric unit and mental health units. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. There is a spacious dining room in the hospital. The dining rooms for the psychogeriatric and mental health units are currently being reconfigured and refurbished. There is a small hairdressing salon.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The laundry currently does all laundry for five Bupa facilities. It is large and airy. There is a supervisor and nine staff who work on a rostered system from 6.00 am to 6.00 pm. There is a van which delivers laundry to and from other facilities. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual and there are safety data sheets visible. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away. All chemicals on the cleaners' trolley were labelled. There are sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice rooms and the laundry are kept closed when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency management plan in place to guide staff in managing emergencies and disasters. Emergency equipment is available at the facility. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Fire safety and emergency management training is provided to staff. Staff interviewed confirmed their understanding of emergency procedures. There is appropriate equipment to respond to a fire and other clinical emergencies. Equipment is maintained by the external contractors. A minimum of one person is available 24 hours a day, seven days a week, with a current first aid/CPR certificate. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 20 March 2019. Civil defence and pandemic/outbreak supplies are available and are checked three monthly. Staff emergency

		and disaster management training is provided to staff. There is sufficient water stored (two water tanks and well water) to ensure ten litres per resident for three days. Alternative heating and cooking facilities (BBQ and portable gas cooker) are available in the event of a power failure. There is emergency back-up lighting available for up to four hours. Smoke alarms, sprinkler system and exit signs are in place. The facility is secured at night. There are calls bells in all resident rooms and communal areas. Residents were observed in their rooms with their call bell alarms in close proximity. Visitors and contractors sign in at reception when visiting.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents smoke. Currently there are four smokers. All other areas are smoke free.
Standard 3.1: Infection control management 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.	FA	Bupa has an established infection control (IC) programme that is implemented at Parkhaven. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. Two RNs are the designated infection control coordinators. One of these is the clinical manager. Both coordinators meet to review infection control matters. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the	FA	There are adequate resources to implement the infection control programme at Parkhaven. The infection control coordinators have attended infection control study days and completed online training. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.

infection control programme and meet the needs of the organisation.		
Standard 3.3: Policies and procedures 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.	FA	The infection control manual outlines a range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least annually.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control coordinators. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved (there have been no recent outbreaks). Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2018 and 2019.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control	FA	The infection control coordinators use the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed on Riskman for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control coordinators. Infection control data is collated monthly and reported at the quality meetings. Minutes of this meeting are posted on the staff noticeboard. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP who advises and provides feedback/information to the service. Systems in place are appropriate to

programme.		the size and complexity of the facility. The facility benchmarks with other Bupa facilities.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The service has documented systems in place to ensure the use of restraint is actively minimised. There are 11 residents (10 hospital residents and one PG resident) with 14 approved restraints (eight bed rails, four lap belts, and two low beds) and seven residents (all hospital) with eight enablers (two bed rails, five lap belts, and one low bed). Assessment, evaluation forms and care plan interventions/risks were documented in the resident files reviewed for three residents with restraints and three residents using enablers. Training around restraint and enabler use has been provided to staff, last completed in September 2018. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP) and enabler usage.</p> <p>All residents in the mental health unit are environmentally restrained in that they are unable to access their bedrooms during the day independently. This is because the high acuity of the residents in the unit means they require close observation and it is essential that staff are aware of where they are in the unit at all times, and the bedrooms are outside the line of the vision when staff are in the lounge. Residents are able to access their rooms when required as staff open the door to the hallway whenever they want down there. Staff support/supervise residents to access their rooms whenever they want. This was observed during the audit. Environmental restraint is well documented and managed in care plans and through discussion with staff which evidences that residents are not restricted to access their environment.</p>
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 approval process is described in the restraint minimisation policy. The roles and responsibilities for the designated restraint coordinator (RN) and for staff are documented and understood, evidenced in interviews with the restraint coordinator and care staff. The restraint approval form identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.

Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Either an RN or the restraint coordinator/RN undertakes assessments in partnership with the resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Three residents' files were reviewed where restraint was in use (one lap belts and two bed rails). Ongoing consultation with the resident and family/whānau were evident. Completed assessments considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints include (but not limited to) bed rails, lap belts and low beds. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident and family and the restraint coordinator. The use of restraint is linked to the residents' care plans. Internal audits measure staff compliance in following restraint procedures. Each episode of restraint is scheduled to be monitored at pre-determined intervals depending on individual risk to that resident. A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the ongoing reassessment of residents on the restraint register, and as part of the six-monthly care plan review. Families are invited to be included as part of this review. A review of three resident files of residents using restraints identified that evaluations were up-to-date.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraints are discussed and reviewed at the six-monthly Bupa teleconference restraint meetings, which are attended by the restraint coordinators from the Bupa aged care facilities. Meeting minutes include (but are not limited to) a review of the restraint and challenging behaviour education and training programme for staff and review of the organisation's restraint policies and procedures.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Twenty-one caregivers are rostered to work in the garden wing (psychogeriatric and mental health unit). Two caregivers who have been employed for over 18 months have not completed the required dementia standards.	Two caregivers who have been employed for over one year and work in the garden wing (psychogeriatric and mental health unit) have not completed the required dementia standards.	Ensure that all staff who have been employed for over 18 months complete the required dementia standards before they are rostered to work in the psychogeriatric unit. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the	CI	Meal time for most cultures throughout the world is a time to relax and share food with family and friends. It was thought that just because residents were living in Parkhaven, it didn't mean that they couldn't enjoy a nice meal experience. The facility formed a dining enhancement committee to make this happen. Prior to the start of the project, hospital residents ate their meals	The facility converted a small lounge in the hospital into a dining room. Now residents eat at small tables which is a much more congenial situation with an environment conducive to eating. The committee then liaised with the kitchen to ensure that the new processes they wanted in place could be coped with by the kitchen. The kitchen was very accommodating. The committee then held an education session for the rest of the staff and two RNs were assigned to support staff throughout the 'roll out'. The following goals have been met; 1) there is a seating plan so residents sit in the same place just like they would at home, 2) there is a table rotation so that every table has a chance to be served first, 3) staff serving in the dining room are expected to wear an apron, a burgundy colour so staff know it is only used for that purpose, 4) residents have their hands washed prior to meal times, 5) there are table napkins available for those that don't need clothing protectors, 6) there is one staff member assigned to each table and staff are expected to assist residents with meals and initiate conversation, 7) each staff member has a special duty (e.g., offering each table seconds, 8) only one course is served at a time and the meal must be covered with a lid, 9) there is an alternative choice of menu at each meal, 10) faces and hands are washed after the meal if required, 11) food and fluid charts to be filled out immediately after each meal, RNs will put these in the dining room. Goals still to be achieved

consumer group.		<p>at a long table in the lounge with the day care residents. Those who couldn't fit at the table ate in their chairs with an over bed table.</p>	<p>are, 1) for those bed bound residents tray service and delivery to be improved further, 2) more barbeques to be held in the summer, 3) the psychogeriatric and mental health unit dining experience to be further brought into line with that in the hospital.</p> <p>The residents, family and staff have expressed satisfaction with the new dining experience. Staff took a little time to adapt but are totally on board now. The care home manager stated that there is still some fine tuning to be completed.</p>
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End of the report.