

# Bupa Care Services NZ Limited - Liston Heights Rest Home & Hospital

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## 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:

<b>Legal entity:</b>	Bupa Care Services NZ Limited
<b>Premises audited:</b>	Liston Heights Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 15 August 2019 End date: 16 August 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	59



# Executive summary of the audit

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## 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 Liston Heights rest home and hospital is part of the Bupa aged care residential group. The service provides rest home, hospital and dementia level of care for up to 75 residents. On the day of the audit, there were 59 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 the review of policies and procedures, the review of resident and staff files, observations, and interviews with family, management, staff and a general practitioner.

The care home manager is a registered nurse and has been in the role for nine months. She is supported by a clinical manager with aged care experience and has been at Liston Heights for 22 years and in the clinical manager role for 18 months. The clinical team is supported by a regional operations manager who is based at the site.

The residents and relatives spoke positively about the staff and the care provided at Liston Heights.

There are improvements required around long-term care planning, care plan interventions, monitoring and staff education.

## 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 at Bupa Liston Heights strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Information on informed consent is included in the admission agreement and discussed with residents and relatives.

## 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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Bupa Liston Heights is implementing the organisational quality and risk management system that supports the provision of clinical care. Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Resident/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents

are reported and followed through. An education and training programme have been implemented with a current training plan in place. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. 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.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is a comprehensive admission package available prior to or on entry to the service. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. A sample of residents' files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Planned activities are appropriate to the resident groups. The programme includes community visitors, outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each consumer group. Caregivers provide activities for residents in the dementia care unit. The residents and family interviewed confirmed satisfaction with the activities programme.

Staff responsible for medication management have current medication competencies. Medication policies reflect legislative requirements and guidelines. The medicine charts reviewed met legislative prescribing requirements.

All meals and baking is done on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. The menu is reviewed by the dietitian. There are nutritious snacks available 24 hours. Residents commented positively on the 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.		Standards applicable to this service fully attained.
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Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe, secure and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant.

## 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. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had two residents using restraint. Assessments and evaluations are regularly completed.

## 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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Bupa Liston Heights has an infection control programme that complies with current best practice and is appropriate for the size, complexity and degree of risk associated with the service. The infection control manual includes a range of policies. There is a dedicated infection control nurse who has a role description with clearly defined guidelines. The infection control programme is reviewed annually at organisational level and links to the quality and risk management system. Infection control education is provided at orientation and incorporated into the annual training programme. Surveillance is undertaken and records of all infections are kept and provided to head office for benchmarking. Staff and residents are offered the annual flu vaccine. There have been no outbreaks since the last audit.

## 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)
<b>Standards</b>	0	46	0	4	0	0	0
<b>Criteria</b>	0	97	0	4	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 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. 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, four registered nurses, one care home manager, one clinical manager, two cooks, one cleaner, one laundry, one maintenance and one activities person), 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 to make informed choices and give informed consent.</p>	FA	<p>There was informed consent policies, procedures and advanced directives in place. Signed admission agreements and general consent forms were sighted in all eight resident files sampled (three rest home including one resident on respite, two dementia and three hospital level of care including one younger person with a physical disability). Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose.</p> <p>There was evidence in files sampled of family/EPOA discussion with the GP for medically indicated not for resuscitation status where residents were not deemed to be competent. Caregivers confirmed verbal consent is obtained when delivering care. In the files sampled, there was an appropriately signed resuscitation plan and advance directive in place. Discussions with residents and</p>

		<p>family/whānau where appropriate, demonstrated they are involved in the decision-making process, and in the planning of resident's care.</p> <p>Copies of enduring power of attorney (EPOA) were sighted in the resident files in the dementia unit.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<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	<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 residents to ensure they are able to participate in as much as they can safely and desire to do. Resident meetings are held quarterly.</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 complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using a complaints register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. Five complaints received since December 2018 were reviewed with evidence of appropriate follow-up actions taken. A sixth complaint was received by auditors at time of audit and was forwarded to the care manager.</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 registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All five residents (two</p>

		rest home level and three hospital level) and seven relatives (three hospital, two rest home and two dementia) 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>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 identifies as Māori is living at the facility.</p> <p>Māori consultation is available through the documented iwi links and Māori staff who are employed by the service. They have a Māori caregiver who is their cultural advisor on site. 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: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff received training on cultural awareness in May 2019.</p>
Standard 1.1.7: Discrimination	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>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.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. The residents have retained their own general practitioner. The general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist's visits. Physiotherapy services are provided on site, six hours per week. There is a regular in-service education and training programme for staff (link1.2.7.5). A podiatrist is on site every six-weeks on and request. The service has links with the local community and encourages residents to remain independent.</p> <p>There are six RNs with specific portfolios, these include; Palliative Care, Infection Prevention and Control wound care, Restraint, Manual Handling and emergency care.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<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 each resident's file. 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 read to residents who require assistance.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The 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 are to pay for that are not covered by the agreement.</p>

<p><b>Standard 1.2.1: Governance</b></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>Liston Heights Rest Home and Hospital is a Bupa residential care facility. The service currently provides care for up to 75 residents at hospital (medical, geriatric), rest home and dementia level care. On the day of the audit, there were 59 residents. There were 15 hospital residents and 6 rest home residents in the hospital wing [all 32 rooms in the hospital wing are dual-purpose] and 31 rest home residents (including two respite residents) in the 31 bed rest home wings. There were 7 residents in the 12-bed secure dementia wing. The rest home services are delivered across two floors. One hospital resident was admitted under a young person with disability contract and another hospital resident was on a long-term chronic health contract. All other residents were under the aged related 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.</p> <p>Liston Heights is part of the midlands Bupa region and the managers from this region meet quarterly to review and discuss the organisational goals and their progress towards these. The care home manager provides a weekly report to the Bupa operations manager. The operations manager teleconferences monthly and completes a report to the director of care homes and rehabilitation.</p> <p>The care home manager has been in the role since December 2018. The care home manager is a registered nurse with a current practising certificate. She has been a clinical practice nurse for ten years following numerous years of practice in public hospital and community practice. She holds a Postgraduate Diploma in Nursing and a Master of Management in Health Service Management. A clinical manager has been in the role for eighteen months. The clinical manager was previously a registered nurse and unit coordinator at Liston Heights. Staff spoke positively about the support/direction and management of the current management team.</p> <p>The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>A clinical manager/registered nurse (RN) who is employed full time, supports the care home manager, and steps in when the care home manager is absent. The operations manager, who is based at the site, supports both managers.</p> <p>The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and promotes quality of life.</p>

<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management programme is well established. Interviews with the managers and staff reflect their understanding of the quality and risk management systems.</p> <p>The Quality Goals for 2019 include (i) skin tear reduction (ii) the reduction of resident falls across the facility. These goals had been carried on from 2018 and there had been a reduction in falls of 20.8%. Falls actions, and progress to meeting these goals is documented. At time of audit, results of the 2019 annual survey were still being received. From the relative responses to date, all categories (with the exception of activities and dementia care) received a higher satisfaction rating than in 2018. A corrective action plan is in place addressing the areas that were lower than 2018. A survey of new residents (two) in July 2019 indicated excellent results.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed.</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. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrated a culture of quality improvements.</p> <p>A health and safety system is in place. Hazard identification forms and a hazard register are in place. The care home manager is the health and safety officer and is enrolled for upcoming health and safety training. Two members of the health and safety committee have completed health and safety training.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an</p>	<p>FA</p>	<p>Individual reports are completed for each incident/accident, with the immediate action noted and any follow-up action(s) required. The nationwide Bupa Riskman electronic system is used. Each event involving a resident reflected an initial clinical assessment by a registered nurse. Follow-up actions had been completed (link 1.3.6.1). Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Ten accident/incident forms were reviewed. Incidents are benchmarked and analysed for trends.</p> <p>Discussions with the care home manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Since last audit the</p>

open manner.		only notification made had been that of the change of care manager.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files reviewed evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained.</p> <p>The service has a comprehensive 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. New staff are buddied for a period of time (eg, caregivers and RNs three weeks), and during this period they have a supernumerary role. The caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively 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>An orientation day (for newly recruited staff) is held monthly if there is more than one new staff member, if not it is done one-on-one on floor, to ensure they are supported with the completion of their orientation documentation. The content of the day aligns with their orientation book.</p> <p>There is an annual education and training schedule being implemented. Attendance numbers at education sessions has not been consistently high. Opportunistic education is provided via toolbox talks. Education and training for clinical staff is linked to external education provided by the district health board.</p> <p>A competency programme is in place with different requirements according to work type (eg, support work, registered nurse, and cleaner). Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files).</p> <p>RN competencies include assessment tools, blood sugar levels/insulin administration, controlled medications, moving &amp; handling, nebuliser, oxygen administration, tube feeds, restraint, wound management, cardiopulmonary resuscitation and syringe driver.</p> <p>Five of eleven registered nurses are interRAI trained. Four of twelve caregivers working in the dementia unit have completed the required dementia course modules qualifications.</p>
Standard 1.2.8: Service Provider Availability	FA	The staffing levels meet contractual requirements. The care home manager and the clinical manager are on-call after hours. The care home manager and clinical manager are available during weekdays.

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>Adequate RN cover is provided 24 hours a day, seven days a week. Feedback/interviews from relatives, residents and staff indicated that often staff were very busy.</p> <p>The staffing levels meet contractual requirements. The care home manager and clinical manager are available during weekdays and are on-call after hours with other RNs. Adequate RN cover is provided 24 hours a day, seven days a week. Sufficient numbers of caregivers' support the unit coordinators and RNs. Staff interviewed advised that there are sufficient staff on duty at all times.</p> <p>In the hospital unit (Liston and Tauhara wings), there were 15 hospital residents and 6 rest home. On the morning shift, there is one RN on duty on the morning and afternoon shifts and one on the night shift. The RNs are supported by five caregivers on the morning shift, three on the afternoon shift and one caregiver on the night shift.</p> <p>In the rest home unit (CA1 and CA2 wings) there were 31 rest home residents. On the morning shift there is one-unit coordinator on duty, who is supported by three caregivers on the morning and afternoon shifts and one caregiver on the night shift. In the Ngauruhoe dementia unit, there were 7 of 12 residents. On the morning shift there is one-unit coordinator on duty, who is supported by two caregivers on the morning and afternoon shifts and there is one caregiver and on the night shift. On the afternoon and night shifts there is one RN from the hospital unit that covers across the rest home and dementia units. Residents and family members interviewed reported that there are adequate staff numbers to attend to residents</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>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p> <p>Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation.</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</p>	<p>FA</p>	<p>There is a comprehensive admission policy. Residents are assessed prior to entry to the service by the Need's Assessment team. Specific information is available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service and residents and/or family/whānau are provided with associated information such as the Code, how to access advocacy and the health practitioners code. There is also specific information for relatives in relation to the dementia unit. All</p>

services has been identified.		<p>relatives interviewed were familiar with the contents of the pack.</p> <p>The care home manager and clinical manager screen admissions prior to entry to ensure a needs assessment has been completed and the service is able to provide the level of care required, if there is a room available. The seven admission agreements sighted (for long-term residents) aligned 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 from services.</p>	FA	<p>There is a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record is kept and a copy of which is kept on the resident's file. All relevant information is documented on the Bupa transfer form and accompanied with a copy of the resident admission form, most recent GP consultation notes and medication information. Resident transfer information is communicated to the receiving health provider or service.</p> <p>There is documented evidence of family notification of appointments and transfers. Relatives interviewed confirmed that they are notified and kept informed of the resident's condition.</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 comprehensive policies and procedures in place for all aspects of medication management. There were no residents self-administering on the day of audit. There was one large medication room in the hospital section, both the rest home and dementia units had locked offices/rooms where the medication and medication trollies were stored. The medication fridge had daily temperature checks recorded and were within normal ranges. Registered nurses or senior caregivers administer medications who have completed their annual competency assessment. There is a signed agreement with the pharmacy. The facility uses a robotics pack medication management system for the packaging of all tablets. Eyedrops and other liquid medications were dated on opening.</p> <p>The facility utilises an electronic medication management system. The sixteen medication charts reviewed (eight hospital, four rest home and four dementia care) had photo identification and allergy status documented on the chart. All medication charts evidenced three monthly reviews by the GP. Prescribed medication is signed after being administered as witnessed on the day of the audit. All 'as required' medication prescribed had indications for use documented by the GP. Effectiveness of 'as required' medication administered was documented. The resident's GP monitors the use of antipsychotic medication. Each resident has a current standing order as evidenced in the medication folders.</p>
Standard 1.3.13: Nutrition, Safe	FA	All meals are prepared and cooked on site. The service utilises a four weekly summer and winter

<p>Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>menu that has been reviewed by a dietitian. There is a full time cook, that also serves as the kitchen manager who works four days on and four days off per week. There are four morning and afternoon kitchenhands that support the cook, including one kitchenhand that is an assistant cook. Meals are served from the bain marie in the kitchen to residents in the hospital dining room and transported in hot boxes to the kitchen bain maries in both the rest home and dementia units and served by care staff. The cook/kitchenhands help serve the meals in the hospital wing at lunchtime. All kitchen staff (one cook, one assistant cook and three kitchenhands) have NZQA167 qualifications.</p> <p>Resident likes and dislikes are known, and alternative choices offered. The residents have a nutritional profile developed on admission and the kitchen staff receive a copy, which identifies the residents' dietary requirements and likes and dislikes. Special diets include gluten free, diabetic and moulid. The cook is notified of any residents with weight loss. Protein drinks and fluids were available in the kitchenette fridges. There were nutritious snacks available 24 hours in the dementia unit. Lip plates and specialised utensils are provided to promote and maintain independence with meals. Fridge, freezer and end cooked meat temperatures are taken and recorded daily. Perishable foods sighted in the kitchen and facility kitchenette fridges were dated. The dishwasher is checked regularly by the chemical supplier. Staff have received training in chemical safety. Chemicals are stored safely. A signed cleaning schedule is maintained.</p> <p>Staff were observed assisting residents with their midday meal on both the audit days. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is an admission information policy. The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry to potential residents and communicates this to potential residents/family/whānau. Potential residents would be referred back to the referring agency if entry is declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	FA	<p>The service uses the Bupa assessment booklets and person-centred templates for all residents. The assessment booklet includes; falls, Braden pressure area, skin, mini nutritional, continence, pain (verbalising and non-verbalising), activities and culture. Nutritional and dietary requirements are completed on admission. Additional risk assessment tools include behaviour and wound assessments as applicable.</p>

manner.		An interRAI assessment is undertaken within 21 days of admission and six monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others as verified in the staff and family/whānau interviews. InterRAI assessments, assessment notes and summary were in place for the seven long-term resident files reviewed. The respite residents file had comprehensive short stay assessments completed on admission. The outcomes of the assessments are overall reflected in the care plan (link 1.3.5.2).
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>The respite care resident (rest home) was not required to have a long-term care plan, however the initial assessment and care plan sighted was completed on time. The seven long-term care plans reviewed recorded the resident's problem/need and objectives/interventions to support resident needs and goals, however not all long-term care plans had documented interventions that reflected the residents' current needs and goals. A care plan summary for each resident provides a guide for caregivers to follow. Staff interviewed reported they found the plans easy to follow. Two hospital level residents that had mood and depression and one resident with dementia that had challenging behaviours identified, did not have behaviour management plans in place that included triggers, behaviours and interventions including de-escalation strategies such as one-on-one time and activities.</p> <p>All seven long-term resident files demonstrated service integration and evidence of allied health care professionals involved in the care of the resident such as mental health services for the older person team, podiatrist and physiotherapist.</p> <p>Residents (as appropriate) and their family/whānau confirmed they were involved in the care planning process as evidenced in the family contact form and on interview. Short-term care plans reviewed were in use for changes in health status. Short-term care plans were reviewed and resolved or added to the long-term care plan if the problem was ongoing.</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>	PA Low	<p>The registered nurses complete care plans for residents. Progress notes in all eight files sampled had detailed progress which reflected the interventions detailed in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. There were 14 wounds (five in the rest home, one dementia unit and eight in the hospital unit) being treated in the facility comprising of five legs ulcers and nine skin tears. There were no pressure injuries at the time of audit. All wounds had wound assessments, plans and ongoing evaluations completed. All chronic wounds were documented in the long-term care plans with interventions for care staff around the dressing changes, signs and symptoms of infection and position changes. Photographs were taken to reflect improvement or deterioration.</p>

		<p>Sufficient continence and dressing supplies are available as confirmed in staff interviews.</p> <p>Interviews with registered nurses and HCAs demonstrated understanding of the individualised needs of residents. Monitoring forms reviewed included monthly weight and vital sign monitoring, food and fluid charts, behaviour charts and daily activity check lists, however there were shortfalls around monitoring of residents with restraints and neurological observations post unwitnessed falls. One resident with a two-hourly turning chart in place did not have documentation completed as required.</p> <p>The short-term care plans evidenced appropriate interventions to manage short-term changes in health.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The services employ two activity coordinators that work four days on and four days off per week. The activity coordinators are involved in the admission process completing the initial activities assessment and has input with the cultural assessment, 'map of life' and 'my day my way' adding additional information as appropriate. The activity programme covers activities across the rest home, hospital and dementia unit seven days a week. Both the activities coordinators have first aid certificates. All activities plans were completed within timeframes, a monthly record of attendance to activities is maintained and evaluations are completed six-monthly. A copy of the weekly activities programme is in the resident's room. The monthly and weekly programmes are displayed on noticeboards throughout the facility and the daily programme written on whiteboards in the lounges as evidenced during the audit. There are a general range of activities for all residents to join in and activities for more able residents.</p> <p>The activities coordinator stated that the programme may vary according to resident requests such as playing different games or outings delayed due to weather, or extra outings if weather is nice in the summer. The activity team provide individual and group activities for all residents that includes; craft, music, exercises, reminiscing, baking entertainers and weekly van outings. One-on-one activities occur such as individual walks, reading and chats and nail/hand care for residents who are unable or choose not to be involved in group activities. Van outings included (but are not limited to) visits to other facilities for competitions, and games, trip to the dam and the local A &amp; P show. Community links are maintained with church groups, grey power, age concern, community speakers, local kapa haka groups and other community clubs and groups.</p> <p>Caregivers on duty in the dementia unit incorporate resident small group and individual activities as part of their duty as witnessed during the audit. Caregivers interviewed were able to describe how they met the resident's individual recreational preferences. Individual participation records are maintained in all resident files reviewed.</p> <p>Activities for younger people included van rides when weather is nice, walks in wheelchairs, family</p>

		<p>visits, colouring in books and music. The activities coordinator stated they take time to get to know these residents and what their hobbies and interests have been prior to commencing the programme. Activities coordinators ensure that the activities programme, involvement and pace are set by the resident. There is a range of music available to listen to right up through the ages. There are three-monthly resident meetings, where residents have the opportunity to provide feedback on all aspects of the facility including activities.</p> <p>Residents interviewed stated they feel the activities are good, and they are kept as busy as they want to be.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The care plans are reviewed and evaluated by the registered nurse at least six-monthly or more frequently to reflect changes in health status, in four of seven long-term files sampled. One respite resident had been in the facility for two months and the other three (one rest home and two dementia care) residents had been in the facility for less than six months. Six monthly multi-disciplinary reviews (MDR) and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the activities coordinator and any other relevant person involved in the care of the resident. Family members are invited to attend the MDT review. The review checklist identifies the family member who has attended the review. There is at least a one three-monthly review by the medical practitioner. There are short-term care plans available to focus on acute and short-term issues. These are evaluated at regular evaluations. Wound care charts were evaluated in a timely manner. Care plans are updated when needs change.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referrals to other health and disability services were evident in the sample group of residents' files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. Examples of referrals sighted were to occupational therapist, physiotherapy, dietitian, mental health services, speech language therapist, and RN community mental health nurse, and hospital specialists. Discussions with the clinical manager and three registered nurses identified that the service has access to GPs, ambulance/emergency services, allied health, dietitians, physiotherapy, continence and wound specialists, and social workers.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of</p>	FA	<p>There are documented policies and procedures in place for the management of waste and hazardous substances to ensure incidents are reported in a timely manner. Chemicals are correctly labelled and</p>

<p>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>stored in locked cupboards throughout the facility. Staff training on chemical safety, management of waste and hazardous substances has been evidenced. Safety datasheets and product wall charts are available to all staff. Approved sharps containers are available and meet the hazardous substances regulations for containers. Gloves, aprons and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff were observed wearing appropriate personal protective clothing when carrying out their duties. Cleaning staff take cleaning trolleys into the resident rooms or they are in their line of sight so that chemicals are not left unattended.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current building warrant of fitness, which expires on 1 September 2019. There is a full-time maintenance person on staff who works 25 hours a week and is on call after-hours and on weekends. There is a 52-week planned preventative and reactive maintenance programme in place. The checking of medical equipment including hoists, has been completed annually. The hot water temperatures are monitored weekly on a room rotation basis. Temperatures were recorded between 39 – 45 degrees Celsius. The living areas are carpeted, and vinyl surfaces exist in bathrooms/toilets and kitchen areas. The building has two levels with a lift and stair access between the two rest home wings. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the facility with mobility aids, where required.</p> <p>There is outdoor furniture and seating with shade sails in place and a ramp for wheelchair access to all external areas. There are two designated resident smoking areas outside the rest home and hospital area. The secured unit has keypad entry and exit access. The outdoor area in the dementia unit is secured with a padlock on an external gate and gardens are well maintained with easy access from lounge areas. There are two external doors from the secure unit, one with a sensor that opens into the secured outside deck area with shaded seating and raised gardens.</p> <p>The registered nurses and caregivers interviewed stated that they have sufficient equipment referred to in care plans and necessary to provide care.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal</p>	<p>FA</p>	<p>There is a mix of hospital rooms with and without ensuites. All the rest home rooms have ensuites. There are adequate numbers of communal toilets and shower facilities in the hospital wings. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Slide signs indicate whether the communal toilet/showers are vacant or in use. The dementia unit has adequate communal toilets and showering facilities identified with the same colour doors and large pictorials. All rooms have hand basins. Residents interviewed confirmed care staff respect the resident's privacy</p>

hygiene requirements or receiving assistance with personal hygiene requirements.		when attending to their personal cares.
<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	All bedrooms are single. The bedrooms are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Staff interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms have wide doors for bed evacuation or ambulance trolley access. Residents are encouraged to bring their own pictures, photos and small pieces of furniture to personalise their room. A tour of the facility evidenced personalised rooms including the residents own furnishing and adornments.
<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 spacious open plan large lounges and dining rooms in the rest home, hospital and dementia wings. There are seating alcoves throughout the facility for residents and families. The service has a family room with tea/coffee making facilities. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Residents can move around freely and furniture is well-arranged to facilitate this. The hospital dining room is adjacent to the main kitchen. All the dining rooms and lounges accommodate specialised lounge chairs as evidenced on the days of the audit.</p> <p>Seating and space is arranged to allow both individual and group activities to occur. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. Care staff assist or transfer residents to communal areas for dining and activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are policies in place including cleaning department, use of equipment policy and cleaning schedules. There is a cleaning schedule/methods policy for cleaners. All laundry and personal clothing is laundered on-site. There are dedicated laundry staff on duty from 7 am – 2 pm daily. There is a defined clean/dirty area within the laundry which also has an entry and exit door. There is a designated washing machine and dryer in the event of an outbreak. The laundry has a label machine for residents clothing to minimise lost items. Chemicals are stored securely in the laundry area.</p> <p>There are dedicated cleaners for each of the service areas, working from 7 am -2 pm daily. Cleaning products are colour coded, for example mop heads for each area. Personal protective equipment is available in the laundry, cleaning and sluice room. Staff were observed to be wearing appropriate protective wear when carrying out their duties. The cleaner's trolleys are stored in locked areas when not in use. Both the laundry and cleaning staff have completed chemical safety training. Cleaning and laundry staff were very knowledgeable around outbreak management. Internal audits monitor the</p>

		effectiveness of the cleaning and laundry processes. The chemical supplier conducts quality checks on the effectiveness of washing and cleaning processes.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation attendance documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment including oxygen and suction is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, backup gas boilers, gas cooking and barbeque. Bupa has a generator that can be sent to the site on request. Emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, toilets and showers and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The facility is secure after hours with call bell access at the front entrance.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>The facility has radiator heating panels throughout the communal areas and resident rooms. All communal rooms and bedrooms are well ventilated and well lit. Residents and family members interviewed stated the temperature of the facility was comfortable. There is plenty of natural light in residents' rooms.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Bupa Liston Heights has an established 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 (Riskman) and Bupa KPIs. A registered nurse is the designated infection control nurse with support from the clinical manager and the quality management committee (infection control team). The infection control nurse has a signed job description. Minutes of the monthly infection control meeting are available for staff. Audits that have been conducted include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Bupa infection control programme is linked into the quality management system and reviewed annually through the north island IC group.</p> <p>Influenza vaccines are offered to residents and staff annually. Visitors and family are advised not to</p>

		visit if they are unwell. There have been no outbreaks at the facility since the last audit. Staff interviewed were well informed about infection control practises and reporting.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse is the designated infection control (IC) nurse and has been in the role since July 2018. She has completed a postgraduate diploma in infection control and attends regular updates and online training sessions. There were adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control nurse and infection control team (comprising the quality management team, kitchen, laundry and care staff) have good external support from the local laboratory, Bupa CSI team and infection control nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities and alcohol hand gel are available in the facility.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</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>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control questionnaires and hand hygiene checklist. Ongoing mandatory infection control training includes food safety, standard precautions, hand hygiene and infection control and prevention. If there is a noted increase in infection rates, there are education sessions held around this. A number of toolbox talks have been provided including (but not limited to) preventing UTIs.</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 (RN) and clinical manager use the information obtained through surveillance to determine infection control activities, trends, resources, and education needs within the facility.</p> <p>Individual infection reports are completed for all infections on the incident management programme (Riskman). Infections are included on a monthly register and a monthly report is collated by the infection control coordinator with a corrective action plan. Infection control data and corrective actions are reported at the quality and staff meetings.</p> <p>The infection control programme is linked with the Bupa quality management programme. The results are subsequently included in the care home manager's report on quality indicators. Internal infection control audits and surveillance of infection control data assists the service in evaluating compliance with infection control practises and identifying infection control needs. There is close liaison with the resident's GP that advise and provide feedback/information to the service.</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>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and regional restraint meetings and at an organisational level. Interviews with the staff confirmed their understanding of restraints and enablers. The focus was on minimising the use of restraint and more sensor mats and mattress perimeter guards were now being used.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had two hospital residents using restraint (one with bedrails, one with a t lap belt). There were no residents using enablers. The two files of the residents on restraint were reviewed. The restraint assessment forms were completed, and clear interventions were in the care plans including associated risks, when the restraints were to be used and the monitoring to be undertaken. Restraints had been evaluated at least three monthly.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes</p>	<p>FA</p>	<p>Only staff that have completed a competency assessment are permitted to apply restraints. Competency assessments expire annually and are renewed by the restraint coordinator. There is a responsibilities and accountabilities table in the restraint policy that includes responsibilities for key staff at an organisation level and a service level. The restraint coordinator is a registered nurse and has a signed job description and understands the role and accountabilities.</p>

(including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. A registered nurse is the restraint coordinator.</p> <p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the resident by the staff. There were restraint assessment tools completed for two hospital residents requiring restraint. The care plans are up-to-date and provided the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family/whānau is also identified.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used.</p> <p>The resident's file reviewed refers to specific interventions or strategies to try (as appropriate) before use of restraint. The care plans were reviewed of the residents using restraint and the care plans identified the observations and monitoring required. Not all required monitoring was documented consistently (link 1.3.6.1). Restraint use is reviewed through the three-monthly assessment evaluation, monthly restraint meetings and six-monthly multidisciplinary meeting and includes family/whānau input.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the</p>	FA	<p>Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the regional restraint approval group and information is disseminated throughout the organisation. The organisation and</p>

monitoring and quality review of their use of restraint.		facility are very proactive in minimising restraint usage.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Person First - Dementia Second training had been held each month February to November 2018 with a maximum of seven staff attending each session. In June 2018 an in-service was delivered on managing behaviours relating to dementia was held (five staff attended), however, requirements of the ARRC contract were not being met. Of 12 caregivers working in the dementia care unit four had completed four dementia unit standards.</p>	<p>Of 12 caregivers working in the dementia care unit four had completed four dementia unit standards. Six of the caregivers had been working in the unit for over eighteen months and had not completed units. Two caregivers who had been working in the unit less than eighteen months had commenced dementia training.</p>	<p>Ensure all caregivers rostered in the dementia care unit have completed level 4 standards within eighteen months.</p> <p>180 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>All resident files reviewed had current initial assessments and care plans completed on admission, routine six monthly interRAI assessments and evaluations completed as per contractual requirements, however not all long-term care plans have been completed as required.</p>	<p>Five (two hospital, two dementia and one rest home level) residents did not have their long-term care plans completed within 21 days of admission.</p>	<p>Ensure all long-term care plans are completed within 21 days of admission as per contractual requirements.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Low</p>	<p>Assessments assist in developing care plan interventions. The long-term care plans that were developed in consultation with the resident/relative had been evidenced in the family contact forms. Long-term care plans for two hospital residents and one dementia care resident had not been updated to reflect the resident current needs and interventions to safely guide staff in the delivery of care. Short-term care plans had been completed for wounds, infections and short-term needs.</p>	<p>(i) Two hospital residents that triggered mood and depression and one resident with dementia that displayed challenging behaviours, did not have behaviour management plans in place to address mood, depression and challenging behaviours.</p> <p>(ii) There were insufficient interventions documented for one hospital level resident admitted with excessive weight.</p>	<p>(i) (ii) Ensure care plans reflect the resident's current needs and supports.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the</p>	<p>PA Low</p>	<p>Monitoring forms are used to monitor residents' health and well-being including blood pressure and pulse, weight, blood sugar levels, behaviour, food and fluid intake, however not all neurological observations for unwitnessed falls and restraints monitoring had been completed. One hospital level resident on a two-hourly turning chart did not have the chart documented as completed.</p>	<p>(i) One hospital level resident did not have a two-hourly turning chart documented as completed.</p> <p>(ii) Three residents with incidents of unwitnessed falls did not have neurological observations completed as per policy.</p>	<p>Ensure monitoring requirements are completed as required and as per policy.</p>

consumers' assessed needs, and desired outcomes.			(iii) Two residents on restraints did not have monitoring charts documented as completed.	90 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.