

# Bupa Care Services NZ Limited - Stokeswood Rest Home & Hospital

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Bupa Care Services NZ Limited
<b>Premises audited:</b>	Stokeswood 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: 29 August 2019 End date: 30 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>	81

# 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 Stokeswood is part of the Bupa group. The service is certified to provide rest home, hospital (geriatric and medical) and dementia care for up to 86 residents. On the day of audit there were 81 residents.

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

The service is managed by an interim care home manager who is an experienced manager and RN, who also manages a close by Bupa service. The clinical manager has worked at Stokeswood since February 2019. The management team is supported by three-unit coordinators and a regional operations manager.

There are systems, processes, policies and procedures documented to provide appropriate quality care for people who live in the service. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

The service has addressed one of the four previous audit shortfalls around the external environment. Further improvements continue to be required around staff training, care plan interventions and medication documentation.

This audit identified improvements required by the service around communication of quality data to meetings and fire evacuations.

## 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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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a business plan with goals for the service that has been regularly reviewed. Bupa Stokeswood has a well-documented quality and risk system. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work

practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activities' person. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a current building warrant of fitness. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. There is safe access to the communal areas and outdoor seating and shade.

## 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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The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were eight residents using restraints and three enablers at the time of the audit.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## 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	13	0	1	4	0	0
<b>Criteria</b>	0	43	0	1	4	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<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 complaint 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. Discussions with residents and relatives confirmed they were provided with information on complaints and complaint forms. Complaints forms are in a visible location at the entrance to the facility.</p> <p>Five complaints received since the last audit were reviewed with evidence of appropriate follow-up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints and actions have included; additional training, one resident being re-assessed to a different level of care, the use of reflective practice for registered nurses (RNs) and the Bupa Head office liaison person maintaining ongoing contact with complainants as needed.</p> <p>The Ministry of Health letter dated 12 December 2018 refers to a Health and Disability complaint. This complaint had been comprehensively investigated by the Bupa CSI team. Actions have included reflective practice by the registered nurses and additional training such as falls prevention, continence care and abuse and neglect. Training around end of life care was not evidenced (link 1.2.7.5). Care plans reviewed did not always document falls prevention strategies (link 1.3.5.2). There was no end of life residents at the time of audit.</p>

<p>Standard 1.1.9: Communication</p> <p>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.</p> <p>Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms reviewed identified family are kept informed.</p> <p>Five relatives interviewed, one hospital level, one rest home and three with family members from the dementia unit, 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.</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 have to pay for that are not covered by the agreement.</p> <p>An introduction to the dementia booklet provides information for family, friends and visitors to the facility. This booklet is 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>Bupa Stokeswood Rest Home and Hospital is a Bupa residential care facility. The service provides rest home, hospital and dementia level care for up to 86 residents. At the time of the audit there were 81 residents; 39 rest home residents including three residents on respite and 24 hospital residents including one younger person disabled and one ACC resident (also under 65 years of age). There were 18 residents in the 20-bed dementia care unit including one funded through the Long-Term Support-Chronic Health Conditions contract (LTS-CHC).</p> <p>A vision, mission statement and objectives are in place. Annual quality/health and safety goals for the facility have been determined and were reviewed April and August 2019 by the manager. Minimising falls is a quality goal for the service and regular falls focus groups have been held as well as training. Falls benchmarking identified a downward trend, however, falls prevention interventions in care plans were not always documented (link 1.3.5.2).</p> <p>The service is managed by an interim care home manager who is an experienced manager and RN, who also manages a close-by Bupa service. The manager stated that she divides her time equally between the two sites. Bupa has booked a Bupa relief manager to take over in a week until a permanent manager has been</p>

		<p>employed. The clinical manager has been in the role for two days, but has been acting clinical manager since February 2019, having previously been a unit coordinator at the service. The management team is supported by three-unit coordinators and a regional operations manager.</p> <p>Care home managers and clinical managers attend annual forums and regional forums six monthly. The care home manager has maintained at least eight hours annually of professional development activities related to managing a rest home/hospital.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>Bupa has a documented quality system and processes. Interviews with the interim manager reflects their understanding of the quality and risk management systems, however the processes have not been well implemented prior to her arrival. 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.</p> <p>Quality and risk data, including trends in data and benchmarked results were not documented as discussed in staff meetings with not all meetings documented as taking place as scheduled.</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 and this has been consistently documented. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented when service shortfalls are identified and signed off when completed.</p> <p>All incidents, complaints, infections, pressure injuries, falls, category one incidents are completed on the online system. Reports are automated and further analysis is completed of those reports. An annual satisfaction survey is completed, and 2018 results demonstrated an 84% positive outcome. Results have been presented to staff, residents and family in poster form.</p> <p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There is a health and safety officer for the service. The health and safety team meet two monthly and document good discussion of infection control and health and safety.</p> <p>Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. The hazard register is reviewed regularly. Strategies are implemented to reduce the number of falls. The falls committee has continued to meet, and they have reviewed all falls and falls minimisation strategies for residents. Falls have continued a downward trend.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<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 benchmarked. 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 regional operations manager. Actions are then followed-up and managed.</p> <p>Nine accident/incident forms were reviewed across the three service areas. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Incidents are benchmarked and analysed for trends. The interim manager was aware of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>There have been seven section 31 notifications made since the last audit. One unstageable pressure injury, two residents absconding, two outbreaks, one broken lock to the secure unit and one alleged theft (the CSI team are currently investigating). All issues raised by section 31 reporting included action plans.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files (one cook, three RNs, one activities staff member and three caregivers) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, but no up-to-date annual performance appraisals. A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. New staff are buddied for a period of time (eg, caregivers two weeks, RN four weeks), and during this period they do not carry a clinical load.</p> <p>There are thirteen caregivers that work in the dementia community/unit and four have completed the required dementia standards, six caregivers are in process of completing their dementia standards but have been employed over 18 months and three new staff members have yet to be enrolled.</p> <p>There is an annual education and training schedule in place. The service provides regular in-service education and sessions have been provided that address all required areas. The service has changed its training process to paid training days, this has improved attendance and ensured all staff have attended at least eight hours training annually. This is an improvement from the previous audit; however, end of life training had yet to be provided following a Health and Disability complaint. Of the ten RNs at Stokeswood, five have completed interRAI training.</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>

		RN competencies include assessment tools, BSLs/insulin administration, CD administration, moving & handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, CPR and T34 syringe driver.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing levels meet contractual requirements. The clinical manager is on-call after hours with other RNs. The care home manager and clinical manager are available during weekdays. 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 dementia unit, there are 18 of 20 residents. On the morning shift there is one-unit coordinator/RN on duty for three days Tuesday, Wednesday and Friday, who is supported by three caregivers. On the afternoon shift, there is one RN (across dementia and rest home units) and three caregivers, and on the night shift, there is one RN (across dementia and rest home units) and two caregivers.</p> <p>In the Hospital unit, there are 24 of 24 hospital residents. On the morning shift, there is one-unit coordinator/RN or RN on duty from Monday to Sunday, who is supported by four caregivers. On the afternoon shift there is one RN and four caregivers, and on the night shift there is one RN and one caregiver.</p> <p>In the rest home unit, there are 39 of 43 rest home residents. On the morning shift there is one-unit coordinator/EN on duty from Monday to Friday, who is supported by three caregivers. On the afternoon shift there is one RN (across dementia and rest home units) and three caregivers and on the night shift there is one RN (across dementia and rest home units) and two caregivers.</p> <p>Residents and family members interviewed reported that there are adequate staff numbers to attend to residents.</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>	PA Moderate	<p>Bupa has comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication chart and any pharmacy errors recorded and fed back to the supplying pharmacy. The service uses an electronic medication management system and robotic packs.</p> <p>Registered nurses, enrolled nurse and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Other competencies completed by RNs included insulin administration and syringe driver.</p> <p>Stock medication including oxygen was being monitored weekly. The medication fridges in each unit had temperatures recorded daily and these were within acceptable ranges. There were no self-medicating residents.</p>

		<p>Twelve medication charts were reviewed, ten computer-based and two paper-based. Photo identification and allergy status were documented. One paper-based chart had no indications for use for 'as required' medication and one did not match the medication blister pack or signing chart.</p> <p>Three charts were reviewed for a resident receiving insulin (one for each area). The chart included records of BSLs and administered insulin (as per GP instructions). All documented blood sugar monitoring as charted and high or low levels had been followed up as per the GP instruction. This is an improvement from the previous audit.</p> <p>Controlled medication was appropriately stored and there were no faxed medication charts, these are improvements from the previous audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service continues to employ one full-time kitchen manager and one-part time cook. There are nine kitchenhands in total. All kitchen staff have current food safety certificates. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are delivered to the wings in bain maries. On the day of audit, meals were observed to be hot and well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and recorded daily. These were all within safe limits. A food control plan has been verified and expires July 2020. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly (or earlier) as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. The national Bupa menus have been audited and approved by an external dietitian.</p> <p>There is a small kitchen off the dementia community/unit dining area. There are adequate snacks available for residents 24/7. The resident and family survey documents 77% satisfaction with meals and residents and family interviewed reported that meals were plentiful and tasty.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service</p>	<p>PA Moderate</p>	<p>Care plans reviewed demonstrated service integration and input from allied health and specialists. For the files reviewed, care summaries and long-term care plan interventions reflected each other, care plans had been updated to reflect six monthly evaluations and obsolete information was closed out. These are all improvements from the previous audit. However, care plans did not all include interventions to support all identified needs. The younger person file included interventions appropriate to a younger person, but not all interventions to support all medical needs. This is a continued shortfall from the previous audit.</p> <p>Residents and family members interviewed confirmed they are involved in the development and review of care</p>

<p>delivery.</p>		<p>plans. Short-term care plans were in use for changes in health status.</p> <p>Two files (dementia level care) reviewed, included specific dementia care plans that included behaviours and de-escalation techniques.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a residents' condition changes the RN initiates a GP visit or specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support was overall good. There was documented evidence of relative contact for any changes to resident health status. Registered nurses were regularly involved in resident daily care and ongoing assessments as identified in the progress notes.</p> <p>Continence products were available and resident files included bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed stated there was adequate continence and wound care supplies.</p> <p>Wound care folders were reviewed in all three areas. A sample of wound documentation was reviewed including a review of the one current pressure injury. Wound assessment and management plans provide a record of wound progress and these were being documented as per policy. Wound tracing and photos were completed for most wounds and specialist input to wound was reflected for the pressure injury and a sacral graze.</p> <p>Monitoring charts were well utilised at Stokeswood and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required.</p> <p>Fall minimisation strategies have included falls training for staff (December 2018 and January 2019) and the implementation of a falls focus group, this group along with the quality meeting and health and safety group document that the service reviews falls at least monthly and discusses strategies to reduce falls on and individual resident basis (link 1.3.5.2).</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</p>	<p>FA</p>	<p>Activities are provided across seven days with activities held during the morning and afternoons. There is a programme in each area with one-on-one activities also provided.</p> <p>There is one trained diversional therapist and three activity assistants. The activity team meet monthly to develop the programme.</p> <p>On the day of audit, residents in all areas were observed being actively involved with a variety of activities.</p> <p>The service continues to implement a varied activities programme across the three services. Group activities</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>are voluntary and developed by the activities staff. Residents were able to participate in a range of activities that were appropriate to their cognitive and physical capabilities. The service has a mobility van that is used for resident outings. The group activity plans were displayed on noticeboards around the facility. There is one programme for the rest home and hospital and residents attend which activity they choose. A separate programme is provided in the dementia community/unit and dementia residents often join (under supervision) concerts and events with the other residents. All residents who do not participate regularly in the group activities are visited by a member of the activity staff with records kept ensuring all such residents are included.</p> <p>Residents are encouraged to maintain links with the community with visits to clubs and other community groups. There are regular entertainers to the home and residents go on regular outings and drives. The family/resident completes a 'Map of Life' on admission, which includes previous hobbies, community links, family and interests. The individual activity plan is incorporated as part of the long-term care plan under the sections 'socialising and activities' and 'my day, my way'. Resident files reviewed identified that the individual activity plan is reviewed at least six monthly. Files reviewed in the dementia community included activity plans across 24/7 as part of the LTCP.</p> <p>Residents/family have the opportunity to provide feedback on the activity programme through resident meetings (with an advocate) and satisfaction surveys. Residents and family interviewed stated the activity programme was varied and there were lots to choose from.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed had been evaluated by registered nurses' six monthly, or when changes to care occurred.</p> <p>Written evaluations describe the resident's progress against the residents identified goals. InterRAI assessments have been utilised in conjunction with the six-monthly reviews. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. There is at least a three-monthly review by the medical practitioner.</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 has a current building warrant of fitness that expires on 30 June 2020. There is a full-time property manager who is available on call for facility matters. Planned and reactive maintenance systems are in place and maintenance requests are generated through maintenance request books. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7.</p> <p>Corridors are wide enough in all areas to allow residents to pass each other safely. Handrails are available in hallways and warning signs are in place for change in floor services. There is access to all communal areas and outdoor areas. There is outdoor seating and shade available in all areas. There is a designated smoking</p>

		<p>area for residents who smoke. The dementia garden area has been landscaped and is now hazard free. This is an improvement from the previous audit.</p> <p>The caregivers and registered nurses (interviewed) state they have all the equipment required to provide the care documented in the care plans. The following equipment is available (but not limited to): electric beds, ultra-low beds, sensor mats, standing and lifting hoists, mobility aids and wheel-on weigh scales.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>There are emergency/disaster management plans in place to guide staff in managing emergencies and disasters. At least one staff member is on duty at all times with a current first aid certificate. Fire evacuation drills have not taken place every six months. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup.</p> <p>Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available. There are civil defence kits in the nurses' station in each unit, the kits are checked monthly. There is sufficient water stored (water tank) to ensure for three litres per day for three days per resident. Call bells were evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. Access by public is limited to the main entrance. The dementia community/unit has a secure entrance.</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>Effective monitoring is the responsibility of the infection control coordinator. Infections are included on Riskman and a monthly report is completed by the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff (link 1.2.3.6). Infections statistics are included for benchmarking. Corrective action plans (CAPs) are established where trends are identified</p> <p>An outbreak of flu like symptoms during July 2019 and an outbreak of gastroenteritis during May 2019 were well managed. The DHB and Public Health were informed, and section 31 notifications were sent.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is</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. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirm their understanding of restraints and enablers. At the time of the audit, the service had eight residents using restraints (bedrails, two lap belts and secure chairs) and three residents' enablers (bedrails). Staff training has been provided around restraint minimisation and management of</p>

actively minimised.		challenging behaviours.
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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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Bupa has a well-documented quality and risk management system that includes a series of meetings to ensure communication and discussion of quality such as complaints and incidents. Not all meetings have been documented as scheduled and meeting minutes do not all document communication of quality results.	<p>(i). Internal audits and complaints are not documented as reported to meetings.</p> <p>(ii). Incident and accident results are reported to RN meetings, but not the staff or quality meetings.</p> <p>(iii). Staff meetings have been documented for February and May only (rather than one to two monthly as</p>	<p>(i)-(iv) Ensure that meetings are documented as scheduled and that meeting minutes reflect communication and discussion of up-to-date quality results.</p> <p>90 days</p>

			<p>scheduled).</p> <p>(iv). The quality meeting viewed for January to August 2019 documented large sections of copied minutes with the meeting minutes for March being an entire copy of January's meeting.</p>	
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>The service provides regular in-service education and sessions have been provided with paid training days, toolbox talks and ad-hoc training. End of life training has not been provided. All staff working in the dementia unit either have the dementia unit standards or are in the process, however staff in the process have not completed within the set timeframes. Staff files document appropriate employment processes, but ongoing staff appraisals are not up to date.</p>	<p>(i). Of the thirteen staff working in the dementia unit, six have not completed the dementia standards within timeframes.</p> <p>(ii). End of life training has not been documented as occurring following a Health and Disability complaint.</p> <p>(iii). Four of five staff files documented that annual appraisals were not up to date.</p>	<p>(i). Ensure that staff who work in the dementia unit have completed the limited credits dementia training within set timeframes.</p> <p>(ii). Ensure end of life training is provided for staff as directed by the Health and Disability response.</p> <p>(iii). Ensure that staff have a documented annual</p>

				appraisal.  90 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The service uses an electronic medication management system with some paper-based medication charts and robotic packs. There was a medication treatment room in each of the three units. Medications were appropriately stored, and stock rotated. The medication fridges in each unit had temperatures recorded daily and these were within acceptable ranges. Twelve medication charts were reviewed across the three units. Photo identification and allergy status were documented. Administration of medications was observed in the three units and all demonstrated safe practice. Shortfalls were identified around documentation of paper-based medication charts and documentation for 'as needed' medication.</p>	<p>(i) One paper-based chart (rest home) had no indication for use for 'as required' medication.</p> <p>(ii) One paper-based chart (dementia); the signing sheet and the blister pack did not match the medication chart.</p>	<p>(i) Ensure that as needed medication includes indications for use; (ii) Ensure medication charts in place reflect what is administered.</p> <p>30 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 Moderate</p>	<p>Six resident files were reviewed for this audit. The respite file reviewed included a short-term nursing assessment and short-stay care plan. Of the five long-term resident files reviewed, the two hospital files had shortfalls around documented interventions. Interviews with caregivers and registered nurses supported knowledge around current care and support required for residents.</p>	<p>(i). One hospital level care plan had not been personalised to reflect the most common reasons and interventions for the resident's high falls and there was no reference to the sacral abrasion in the long-term care plan (or a short-term care plan).</p> <p>(ii). One hospital level care plan did not include the use of a leg brace (an arm sling was identified). There were no instructions for how or</p>	<p>Ensure care plans reflect interventions to support current assessed needs.</p> <p>90 days</p>

			when to apply the leg brace or arm sling.	
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA</p> <p>Moderate</p>	<p>There is a documented emergency plan in place and an approved fire evacuation plan.</p>	<p>The service has not documented any trial fire evacuations since 2018.</p>	<p>Ensure trial evacuations are held six monthly.</p> <p>30 days</p>

## 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.