# Bupa Care Services NZ Limited - Winara Rest Home

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bupa Care Services NZ Limited

**Premises audited:** Winara Rest Home

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

**Dates of audit:** Start date: 21 November 2019 End date: 22 November 2019

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 82

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Bupa Winara Rest Home is part of the Bupa aged care residential group. The service provides rest home, hospital and dementia level of care for up to 86 residents. On the day of the audit there were 82 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 the general practitioner.

The care home manager is a registered nurse and has aged care clinical and management experience with Bupa since 2007. She is supported by a clinical manager with aged care experience. The management team is supported by a regional operations manager.

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

This audit identified areas for improvement around complaints communication, care plan documentation, neurological observations, maintenance documentation and stored water.

The audit has also awarded two continuous improvements around; the activities programme and food services.

## Consumer rights

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk. |

Staff at Bupa Winara 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 are recorded on a register.

## Organisational management

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| --- | --- | --- |
| 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. |  | Standards applicable to this service fully attained. |

The service 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. Residents/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 has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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| --- | --- | --- |
| 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 medium or high risk and/or unattained and of low risk. |

There is an admission package available prior to or on entry to the service including information on the dementia care unit. Registered nurses are responsible for completing initial assessments, interRAI assessments, development of care plans and the evaluation of resident’s care needs in consultation with the resident/relatives. Care plans demonstrate service integration and are reviewed at least six monthly. Resident files included notes by the general practitioner and other allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies annually. The electronic medication records reviewed included documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner.

An activities programme is implemented separately for the rest home, hospital area and for the dementia care unit. Residents and families reported satisfaction with the activities programme. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the groups of residents.

All food and baking are done on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. Meals are well presented, and a dietitian has reviewed the Bupa menu plans. Nutritious snacks are available 24/7 in the dementia care unit.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

Chemicals are stored securely throughout the facility. The buildings hold a current warrant of fitness. There is a reactive maintenance system in place. All rooms are single and have hand basins. There is a mix of ensuites and communal toilets/shower facilities. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. There is a safe external walking path and gardens for the dementia care residents that are freely accessible. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training and information for responding to emergencies is provided. There is an emergency management plan in place. There is an approved evacuation scheme. A first aider is on duty at all times. The temperature of the care home units is comfortable and constant.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint minimisation and safe practice policies and procedures are in place. There were five residents using restraints and one resident using an enabler during the audit. A registered nurse is the designated restraint coordinator. Staff are offered training in restraint minimisation and challenging behaviour management, which begins during their orientation to the service. Staff are also expected to complete a restraint minimisation competency annually.

## Infection prevention and control

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| 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. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Staff receive ongoing training in infection control.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 44 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 2 | 94 | 0 | 3 | 2 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff including six caregivers (two from each of hospital level, rest home and dementia), three registered nurses (one from each of hospital, rest home and dementia) two activity staff, one diversional therapist, three kitchen staff, a housekeeper and maintenance person, demonstrated their understanding of the key principles of the Code. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nine resident files were reviewed (three hospital level including one hospital resident in a dual-purpose bed, three rest home including one respite care and three dementia care resident files). Informed consent processes are discussed with residents (as appropriate) and families on admission. Written general consents and consent for van outings are signed by the resident or their enduring power of attorney (EPOA). General consents include release of information to specific persons. Advanced directives where known are signed for by the competent resident.  There was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order where residents were deemed to be incompetent to make a decision. The EPOA had been activated in the files reviewed of the three dementia care files sighted.  The registered nurses and caregivers interviewed confirmed verbal consent is obtained when delivering care. Discussion with family and relatives identified that the service actively involves them in decisions that affect their relative’s lives.  All long-term resident files reviewed had signed admission agreements. The respite care resident had signed a short-stay agreement. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | 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. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups such as RSA and church groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate. Residents enjoy visits from local schoolchildren and mothers’ groups. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all compliments, complaints, both verbal and written, by using a complaint register (in hard copy and electronically). There have been three complaints year to date for 2019. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed for the complainant in accordance with guidelines set by the Health and Disability Commissioner. Meeting minutes did not document that complaints have been communicated to staff. The investigation of complaints has not always been well documented.  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. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | 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.  All four residents (three rest home level and one hospital level) and seven relatives (two hospital, two rest home and three dementia level of care) interviewed, reported that the residents’ rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | 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 identified 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. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There were two residents that identified as Māori on the day of audit. Cultural considerations were documented though the care plan for both residents.  Māori consultation is available through a local kaumātua. 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. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | 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.  Information gathered during assessment including resident’s cultural beliefs and values, is used to develop a care plan with resident (if appropriate) and/or their family/whānau consultation. Staff received training on cultural awareness in May 2019. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice is evident, promoting and encouraging good practice. Staff and management interviewed reported a strong management team with a low staff turnover.  Registered nursing staff are available seven days a week, 24 hours a day. 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, twice weekly.  Gardens have been revamped and new furnishing have been purchased for the indoors, following feedback from the 2018 survey.  There is a regular in-service education and training programme for staff. Policies and procedures meet current best practice and are readily available to staff. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | 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. Fifteen accident/incident forms were reviewed from October 2019. There is documented evidence of communication with family following an adverse event. Relatives interviewed stated that they are kept informed when their family member’s health status changes.  There are monthly friends and family meetings that promote open communication. An interpreter policy and contact details of interpreters is available.  Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Winara Rest Home is a Bupa residential care facility. The service provides care for up to 86 residents at hospital, rest home and dementia level of care.  On the day of audit there were 82 residents. There were 32 rest home residents, 29 hospital residents (seven in the rest home dual service beds and 22 in the hospital wing) and 21 dementia care residents. There were three rest home level respite residents. Two from the village as part of the village resident’s package of care as needed and one DHB funded respite. All other residents were under the age-related contract.  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. The care home manager provides a weekly report to the Bupa operations manager and there are monthly teleconferences to monitor progress of quality goals.  The service has annual goals that are reported quarterly. The goals for 2019 include; to decrease falls across the whole facility. This was a continued goal from last year. To improve the dining experience and to continue to implement the kindness initiative. Health and safety goals include a focus on the hazards and risk register and improve reviews of near miss incidents as a learning process.  The care home manager is a registered nurse, she also has management qualifications. She has been with Bupa since 2007. The care home manager is supported by a clinical manager. Staff spoke positively about the support/direction and management of the current management team.  The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service, including; Bupa managers forums, attendance at an interRAI managers training and palliative care modules. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The organisation has acting care home managers who cover the facility care home manager for absences over two weeks. The clinical manager/registered nurse (RN) who supports the care home manager covers short periods of leave. The operations manager, who visits regularly, supports both managers. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Bupa Winara are implementing the Bupa quality and risk programme. 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 at head office. New policies or changes to policy are communicated to staff.  The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, pressure injuries and wounds. Quality data is entered into the organisational Riskman data base. Quarterly reports are generated from the head office including trends and comparison with other Bupa sites. The service develops corrective action plans for adverse trends and where high incidences of adverse events are evidenced.  An annual internal audit schedule including environmental, support services and clinical audits was sighted for the service. Audits had been completed as per schedule and where the result was less than expected corrective action plans had been developed and re-audits completed.  Quality and risk data, and audit results are discussed in quarterly quality meetings, staff meetings and health and safety meetings. Two monthly RN meetings document in-depth discussion of quality results, internal audits and clinically based issues. Complaints discussion has not been well documented (link 1.1.13.3).  Annual surveys are completed with feedback analysed and corrective actions plan developed for areas identified for improvement. The most recent survey documented overall satisfaction with services with responses rating 80% to 89% satisfied. Relatives for the dementia unit documented that they have been 84% satisfied with the dementia unit and care.  Resident meeting minutes evidence discussion regarding care, support, activities and meals as well as discussion around survey results and action plans.  The health and safety committee are representatives from each service area. All policies and procedures meet the health and safety requirements. There are national health and safety goals. Staff interviewed stated they have the opportunity to provide input at the health and safety committee meetings. Hazard management is discussed and there is a current hazard register in place. Falls prevention strategies are managed on an individual basis and minimised. Falls have remained stable in the dementia and hospital units and have documented a downward trend in the rest home. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Individual reports are completed for each incident/accident onto the electronic Riskman data base. Fifteen accident/incident forms for the month of October 2019 were reviewed. Each event involving a resident reflected an initial clinical assessment by a registered nurse and follow-up action and corrective actions implemented and signed off. Neurological observations have not always been documented according to Bupa policy (link 1.3.6.1). The clinical manager reviews all incident forms daily when on duty to ensure follow-up and resident safety. A monthly report is collated, and any trends identified and discussed and addressed through quality meetings and RN meetings.  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. Notifications have included; Section 31s for two stage three pressure injuries and one for a missing resident. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (one clinical manager, two registered nurses, one activities coordinator one cook and four caregivers) evidenced implementation of the recruitment process, employment contracts, completed orientation, at least eight hours attendance at training a year and annual performance appraisals. A register of practising certificates including all health professionals involved in the service is maintained.  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. 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 level two-unit standards. Eleven caregivers work in the dementia unit. All eleven caregivers have completed dementia unit modules.  There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. Each education session has an information resource available, which staff complete if they are unable to attend. Dementia specific training included the Bupa Person First training, managing behaviours that challenge and the aging process. Education and training for clinical staff is linked to external education provided by the district health board. Registered nurses are encouraged to complete their PDRP (professional development recognition programme). Specific competencies are included according to the role such as medications, wound management, cardiopulmonary resuscitation and syringe driver for RNs. Seven of thirteen registered nurses are interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meet contractual requirements. The care home manager and the clinical manager are on duty Monday to Friday and on-call after hours. Interviews with the residents and relatives confirmed staffing overall was satisfactory and increased to manage resident acuity and occupancy. Staffing levels are as follows:  Hospital (22 residents at hospital level on the day of audit): morning shift - one RN, three caregivers on full shift and one short shift; afternoon shift – one RN, three caregivers on full afternoon and one short shift. There is one caregiver and one RN at night.  Rest home (seven hospital level and 32 rest home level residents): one RN, two caregivers on full shift and two short shifts; afternoon shift – one RN, one caregiver on full shift and two short shifts. There is one RN and one caregiver on at night.  Dementia care unit (21 residents on the day of audit); one RN morning and afternoon shifts; two full morning shift and two afternoon shift caregivers. There is one full shift afternoon caregiver.  Activities staff are allocated to the rest home, hospital and three for the dementia care unit.  There are designated food services staff, cleaning and laundry staff seven days a week. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.  Residents’ files demonstrated service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has admission policies and processes in place. Assessing agencies establish the appropriate level of care required prior to admission of a resident. Residents/relatives receive an information pack outlining services able to be provided, the admission process and entry to the service, including admission into the dementia care unit. The care home manager/registered nurse or clinical manager screens all potential residents prior to entry and records all admission enquires. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. Residents who require admission to hospital or transfer are managed appropriately and relevant information is communicated to the receiving health provider or service. The family are asked to accompany the transfer of dementia level of care resident’s to hospital if possible. All supporting documentation accompanies residents to the receiving facility and communication with family is documented. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are policies and procedures in place for all aspects of medication management. Medications were stored safely in the three units. Registered nurses or senior caregivers who administer medications have completed their annual competency assessment. Medication education is provided annually. The RNs check the robotic rolls on delivery against the electronic medication charts and signs a medication reconciliation checklist. ‘As required’ medications are in individual resident bottles and checked regularly for expiry dates. There were no self-medicating residents on the day of audit. Medication fridge temperatures had been checked daily. A bulk supply order is maintained for hospital level residents and is checked regularly for expiry dates and stock levels. Eyedrops were dated on opening. Oxygen and suction equipment is available in the hospital unit.  The facility uses an electronic medication management system. Eighteen medication charts were reviewed (six rest home, six hospital and six dementia). All charts reviewed had photo identification and allergy status identified. All medication charts evidenced three monthly reviews by the GP.  All ‘as required’ medication had indications prescribed for use. Effectiveness of ‘as required’ medication administered was documented in the electronic medication system. Anti-psychotic management plans are used for residents on antipsychotic medications. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals and baking are prepared and cooked in a well-equipped kitchen adjacent to the rest home dining room. The chef is supported by a team of cooks, morning and afternoon kitchenhands who have all completed food safety and hygiene training. The four weekly winter and summer Bupa menu has been reviewed by a dietitian. The menu offers an alternative option such as toasted sandwiches to accommodate dislikes/preferences. Dietary requirements including pureed, vegetarian and diabetic desserts are provided. The kitchen manager receives a nutritional profile for each resident and is notified of any changes to dietary requirements. Daily menu resident lists are delivered to the kitchen. The meals are served by cooks for residents in the rest home dining room. Meals are delivered to the dementia unit in a bain marie and served by caregivers. Meals are delivered in a hot box to the hospital unit kitchenette. A kitchen assistant is based in the hospital unit and serves all meals, fluids and manages the satellite kitchen. Lip plates are provided to encourage resident independence with eating. Staff were observed to be sitting with residents and assisting them with meals and fluids. There were nutritious snacks available 24 hours in the dementia care unit.  The food control plan has been verified. The temperatures of refrigerators, freezers, chiller, incoming chilled goods and end cooked food temperatures are taken and recorded. All food is stored appropriately, and date labelled. The dishwasher wash and rinse temperatures are taken and recorded, and the dishwashers monitored monthly by the chemical provider. Cleaning schedules are maintained. Chemicals are stored safely.  Residents and relatives have the opportunity to feedback on the service through meetings and surveys. Residents and the family members interviewed commented positively on the meals provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The service records the reason for declining service entry to potential residents should this occur and communicates this decision to potential residents/family/whānau and referring/assessment agency. The reasons for declining entry would be if the service has no beds available or unable to meet the assessed level of care required. Anyone declined entry would be referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission in consultation with the resident and their relative (as appropriate). InterRAI assessments were completed for long-term resident files within the required timeframes. An initial nursing assessment booklet including risk assessments (pressure injury risk, falls risk and pain), activities assessment and cultural assessments had been completed for all long-term resident files reviewed. There was a short stay nursing assessment completed for the respite care resident. Behaviour assessments were completed on admission for dementia care residents and reviewed six monthly or earlier if required. The outcomes of assessments formed the basis of the long-term care plans. Assessment process and the outcomes are communicated to staff at shift handovers through verbal and written shift reports. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Long-term care plans reviewed were individualised and included the outcomes of interRAI assessments. Supports were described in the care plans, however not all resident care plans documented interventions to meet the resident goals. Outcomes of assessments were reflected in the care plans. Behaviour management plans and dementia care plans were individualised for dementia residents which included triggers, behaviours and interventions including de-escalation strategies such as one-on-one time and activities.  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, psychogeriatrician, district nurse, wound nurse, podiatrist, dietitian, physiotherapist and podiatrist.  Residents (as appropriate) and their family confirmed they were involved in the care planning process as evidenced in the family/whānau contact form and signature on the care plan. Short-term care plans reviewed were in use for changes in health status such as pressure injury and wounds, post-operative care, unintentional weight loss and infections. Short-term care plans were reviewed and resolved or added to the long-term care plan if an ongoing problem. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident condition changes the RN initiates a GP visit or nurse specialist referral. The family is notified of any changes in the resident health status including incidents/accident, infections, GP visits and medication changes. A record of relative notifications is maintained on the family/whānau contact form in the resident file. Relatives interviewed confirmed they are kept informed and the needs of their relatives are being met. Short-term care plans are used to guide staff in the delivery of care to meet for short-term/acute needs.  Sufficient continence products are available and resident files reviewed included a continence assessment and plan as part of the plan of care. Specialist continence advice is available through the DHB as needed and this could be described.  Staff have access to sufficient medical supplies and wound dressings. Wound assessments, wound management and evaluation forms were in place for 24 residents (across the three service levels) with wounds including skin tears, chronic wounds and leg ulcers. Photos and/or documented sizes of wounds demonstrated healing. There were four stage two pressure injuries (one community acquired, and three facility acquired) and one facility acquired stage one pressure injury. Not all pressure injuries were linked to the resident care plan (link 1.3.5.2). There were pressure injury interventions in place for residents at risk of pressure injuries and pressure prevention equipment was seen to be in use. There is evidence of the district nurse and wound care nurse involved in wound care management.  Monitoring forms are utilised to monitor residents state of wellbeing and the effectiveness of interventions. There was a shortfall around the completion of neurological observations where required. |
| Standard 1.3.7: Planned Activities  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. | CI | The service employs a team of four activity coordinators and one diversional therapist (DT) who coordinate and implement activities in each of the units. There is a five-day week programme in the rest home/dual purpose beds unit and a seven-day week programme in the hospital unit. The activity coordinator for the dementia unit works Tuesday to Saturday with caregivers, incorporating activities as part of their role within the dementia unit. There are plenty of resources available for staff and resident use. There are volunteers involved in the rest home and dementia unit programmes.  Each unit has their own programme with activities that meet the physical, intellectual, emotional abilities of the resident group. Activities offered within the units include a variety of exercises, quizzes, word games, arts and crafts, reminiscing, movies and sing-a-longs, walks, and gardening. One-on-one time is spent with residents who are unable to participate in the programme or choose to stay in their rooms. Each unit has weekly van outings. The van has a wheelchair hoist. Hospital level residents enjoy local scenic drives and picnics. Rest home residents have outings into the community such as 10 pin bowling, visiting garden centres, attending the monthly senior citizens functions and arts and crafts events. Outings for dementia care residents include scenic drives, lunch outings, visiting parks and beaches. Festive occasions and themes are celebrated. The ladies have high teas and there is a gentlemen’s club which has grown in membership over the last year.  There are regular entertainers, church services, pre-school children visit and fortnightly pet therapy.  Each resident has a map of life (profile) and an activity assessment completed on admission. Individual activity plans are incorporated in the long-term care plan which is evaluated six monthly at the MDT review.  The service receives feedback and suggestions for the programme through resident meetings and direct feedback from residents and families. Residents interviewed spoke positively about the activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate initial care plans within three weeks of admission and long-term care plans six monthly. The family/EPOA are invited to attend a multidisciplinary team meeting (MDT). Members of the MDT include the GP, RN, care staff, DT/activity person, resident (as appropriate) and family member. Allied health professionals involved in the resident’s care such as the physiotherapist, psychogeriatric community nurse or dietitian provide input into the MDT evaluation of care. Records of the MDT meeting are maintained, and the cares evaluated against the resident goals. Any changes following the MDT meeting are updated on the care plan (link 1.3.5.2). The family/EPOA are informed of any changes if they have been unable to attend.  Short-term care plans are evaluated regularly and either resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the group of resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate nurse specialist referrals and specialist referrals are made through the GP. The RNs interviewed provided an example of where a resident’s condition had changed, and the resident was reassessed from respite care to dementia level of care. Discussion with the RNs identified that the service has access to a wide range of support either through the GP, DHB specialists and allied health services. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There is a chemical/substance safety policy and waste management policy. Chemicals are stored safely throughout the facility. Safety data sheets are available. Approved sharps containers are available and meet the hazardous substances regulations for containers. Gloves, aprons, and goggles are available for staff at the point of use. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. Staff have attended chemical safety education. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The rest home, dual-purpose beds and dementia unit are within one main building. The hospital building is connected to the main building by a covered walkway. Both buildings have a current warrant of fitness. A maintenance logbook is kept in the nurses’ station for the recording of maintenance requests. The full-time maintenance person checks the maintenance log regularly throughout the day and signs off requests as they are completed. Contractors for essential services are available 24/7. Medical equipment including hoists and weigh scales have been calibrated. Electrical equipment has been tested and tagged. Hot water temperatures in resident areas are monitored monthly and maintained below 45 degrees Celsius. The 52-week planned maintenance schedule has been completed and signed off for 2018, however there is no evidence the 52-week planner has been completed for 2019. Residents rooms have been refurbished as they become vacant. Furnishings have been recovered to brighten up the care home. The gardens and grounds for the rest home and hospital area are being landscaped.  The corridors are wide with handrails to promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and garden landscaping have been well maintained. There is outdoor furniture and seating and shaded areas. There is wheelchair access to all areas.  The dementia unit has a communal lounge with safe outdoor access to the courtyard and walking pathway. The space and seating arrangements provide for individual and group activities.  The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All bedrooms have hand basins. There is a mix of ensuite rooms and rooms with shared ensuites in the rest home/dual purpose unit and the hospital unit. There are communal toilets and showers in the dementia care unit. Toilets are also located near the communal areas. There is appropriate signage, easy clean flooring and fixtures, and handrails appropriately placed. Residents interviewed reported their privacy is maintained at all times. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms are single. The dual-purpose beds in the rest home unit and hospital are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. The bedrooms in the dementia care unit are spacious. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a separate lounge and dining room in the rest home and a second lounge/library that has tea making facilities where quieter activities can take place or for visitors to use. There are many seating alcoves within the rest home building. The rest home gardens have been upgraded. In the hospital there is a large spacious open plan lounge/dining room. The communal lounge/dining room is accessible and accommodates the equipment required for the hospital residents. Seating and space are arranged to allow both individual and group activities to occur. There is a family room in the hospital wing.  There is adequate space in the dementia unit to allow maximum freedom of movement while promoting safety for those that wander. There is an open plan lounge and dining area. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry and personal clothing are laundered on site. The laundry is located in a basement area with a dumb waiter for the transport of linen to and from the laundry. There is a defined clean/dirty area. There are designated laundry and cleaning staff seven days a week. There were adequate linen supplies sighted in the facility linen-store cupboards. Cleaning trolleys were well equipped and stored safely when not in use. The chemical provider monitors the effectiveness of the laundry and cleaning processes. Staff have attended chemical safety and infection control education. Residents and relatives interviewed were satisfied with the laundry and cleaning services provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Fire drills are scheduled every six months. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff.  There are supplies in the event of a civil defence emergency including food, blankets and gas cooking, but not enough stored water as per civil defence requirements. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times at the facility. There are call bells in the residents’ rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity. Security systems are in place to ensure residents are safe. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The facility has underfloor heating throughout the communal areas and ceiling heating in the bedrooms. Residents and family interviewed, stated the temperature of the facility is comfortable. There is plenty of natural light in residents’ rooms and communal areas. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control coordinator (clinical manager) and two RNs are responsible for infection control across the facility. The infection control committee and the Bupa governing body is responsible for the development and review of the infection control programme. The infection control programme is well established.  Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at Winara. The infection control (IC) coordinator has maintained best practice by attending an infection control regional study day May 2019. The infection control committee meet two monthly.  External resources and support are available through the Bupa quality and risk team, external specialists, microbiologist and DHB when required. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a 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. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator completed an organisational two-day orientation to the role. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice, education packages and group benchmarking.  Consumer education is expected to occur as part of the daily cares. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections.  Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.  Infections are entered into the Riskman electronic data base; infection incident rates and trends are reviewed monthly. Corrective actions are established where trends are identified. This was confirmed with a spike of urinary tract infections during October. The spike had a corresponding action plan which had been evaluated and closed off and a subsequent reduction in urinary tract infections.  There has been one confirmed norovirus outbreak in August 2019. Public health was notified with ongoing correspondence during the outbreak period. Case logs and outbreak documentation was sighted. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | 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 clinical manager is the restraint coordinator. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and through quarterly teleconference with Bupa restraint coordinators. Staff receive education on restraint, dementia and challenging behaviours. There was one resident using an enabler on the day of audit, bed rails to assist with moving in bed. There were five residents requiring the use of restraint, this included two low beds and three hand holding restraint when needed. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the RN in partnership with the GP, resident and their family/whānau. Oversight is provided by the restraint coordinator. Ongoing consultation with the resident and family/whānau are evident. Four files for the residents using restraints were reviewed, this included one resident with a low bed and three requiring the intermittent use of hand holding restraint. The completed assessments considered those listed in 2.2.2.1 (a) - (h). One resident with an enabler also had a completed assessment signed by the resident. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.  Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint was linked to the resident’s restraint care plan in all four resident files reviewed for residents with restraint. The hand holding restraint including when to use and how long for.  An internal restraint audit, conducted annually, monitors staff compliance in following restraint procedures.  Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Staff were completing the monitoring forms accurately. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are scheduled three-monthly and frequently occur with greater frequency (eg, two monthly). Restraint use is discussed in a range of meetings (restraint meetings and RN meetings) confirmed in the meeting minutes. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The Bupa restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The service maintains a complaint register both electronically and paper based. There was evidence that complaints had been followed up with toolbox talks, but a full investigation of a more serious complaint was not documented, and meetings did not document that staff had been informed regarding the specific complaint. | (i). One complaint regarding a resident leaving the secure unit had a follow-up toolbox talk around ensuring the door is closed and a section 31 notification. It did not document a full investigation or any reflection on how the service could be improved.  (ii). Meeting minutes did not document that the complaints had been communicated and discussed with staff. | (i). Ensure that complaints are reported to the relevant service meetings.  (ii). Ensure that complaints document a full investigation and, when needed, an analysis of causes and how to improve services.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Supports around the resident activities of daily living, mobility, elimination, medical conditions, skin care, nutrition were described in the care plans; however, not all resident care plans documented interventions to meet the resident goals. | (i) There were no documented interventions for two residents (one hospital and one dementia care) for new pain identified requiring GP involvement and analgesia; (ii) There were no documented interventions for one dementia care resident with a risk of absconding; (iii) There were no documented interventions to reflect one dementia care residents unintentional weight loss; (iv) There were no early warning signs documented in the care plan for one dementia care resident recently discharged from the mental health unit, and (v) The care plans for two rest home residents did not identify the presence of facility acquired pressure injuries. | (i)-(v) Ensure care plans reflect the current health status of residents and describe the supports required to meet the resident goals.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Monitoring forms reviewed included (but not limited to) two hourly turning charts, nutritional records, fluid balance charts, bowel records, weekly/monthly weight, blood sugar levels, vital signs and behaviour charts, pain monitoring; however, there was a shortfall around neurological observations for unwitnessed falls or where there was an obvious knock to the head. | Neurological observations had not been completed as per protocol for four of eight incident/accidents that required neurological observations. | Ensure neurological observations are completed as per protocol for unwitnessed falls and where there has been an obvious knock to the head.  60 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | Both buildings have a current building warrant of fitness. Reactive maintenance is completed as requested. Planned maintenance including testing and tagging of equipment, calibration of resident related equipment and monitoring of resident hot water temperatures but the 52-week planned maintenance schedule had not been completed for 2019. | The 52-week planned maintenance schedule had been completed and signed off for 2018, but there was no documented evidence the 52-week maintenance schedule had been completed for 2019. | Ensure the 52-week planned maintenance schedule is completed.  90 days |
| Criterion 1.4.7.4  Alternative energy and utility sources are available in the event of the main supplies failing. | PA Moderate | The service has a documented civil emergency plan and a range of civil emergency stores. This includes; food for at least three days, blankets, torches, gas burners, barbeques, bags, hammers as examples. There is not sufficient water and civil defence kits have not been checked for 2019. | The service has 1000 litres of water stored; this is not equivalent to the 20 litres per person per day for seven days as per the DHB requirements.  The civil defence stores have not been checked for 2019. | Ensure that sufficient water is stored that meets the DHB water storage requirements for the Wellington region.  Ensure that civil defence stores are checked as per Bupa policy.  60 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | CI | Residents and relatives have the opportunity to feedback on the service through meetings and surveys. Residents and the family members interviewed confirmed there has been an improvement in the meals provided. Annual survey results demonstrate an improved resident satisfaction in the meal service. | An action plan was developed in June 2019 to improve the meals and dining experience. Changes to the menu and dining experience were in consultation with the recently appointed chef, residents and staff. Improvements to date included a choice of condiments on tables, rotation of tables to be served first, ensuring meals are at acceptable temperatures, photos of meals in menu plan and a comments book available in the dining rooms. The chef receives feedback and suggestions from resident meetings and implements these in consultation with the care home manager. The 2018 annual survey for food satisfaction was 76% and in July 2019 survey results were 82% which was above the Bupa average for food services. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | The Gentleman’s club commenced in 2017 as a way of providing companionship and friendships for male residents in the care home. Due to an increasing number of men in the care home the club venue was changed to the apartments. The group is open to men from across the service levels and several men attend from the apartments. Group numbers over 2019 (excluding men from the apartments) average 13 – 17 residents from across the rest home, hospital and dementia unit. | The Gentleman’s group started with a small group of men getting together to reminisce and share stories over a beer and snack. Due to the increasing number of men joining the group the venue was changed to an apartment lounge. This gave the men privacy to engage in their social activities. The group of men from the rest home, hospital and dementia care invited male residents in the apartments to join in. The residents in the apartments found they were able to support other male residents who had moved into the care home. Male care home residents looked forward to the monthly group and catching up with other men with whom they had developed friendships. The male activity coordinator facilitates the group and ensure introductions are made. The men lead the discussion and activities such as barbeques and storytelling over drinks and snacks. Men interviewed described the group as a positive experience that they looked forward to. An auditor observed the Gentlemen’s group in action on the day of audit and confirmed the group enjoyment was obvious with much socialisation and singing with a beer and snacks. Photos and comments were in display books in the hospital wing. |

End of the report.