

Bupa Care Services NZ Limited - Fergusson Rest Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Fergusson Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 March 2020 End date: 3 March 2020
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	108

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Bupa Fergusson rest home and hospital is part of the Bupa aged care residential group. The service provides rest home, hospital and dementia level of care for up to 112 residents. On the day of the audit there were 108 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. 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 Bupa Fergusson.

This audit identified improvements required around; meeting minutes, corrective actions, agency staff induction, staff training, timeframes for assessment and care plans, progress notes, care plan interventions, implementation, self-medication management and water stored for civil defence.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff at Bupa Fergusson ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

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

through. An education and training programme is documented with a current training plan in place. Appropriate pre-employment processes are adhered to. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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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An information pack is available prior to or on entry to the service. Registered nurses' complete initial assessments including interRAI assessments, care plans and evaluations within the required timeframes. Care plans are integrated and include the involvement of allied health professionals. Residents and relatives interviewed confirmed they were involved in the care planning and review process.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting and includes outings, entertainers and community interactions.

Medicines are stored and managed appropriately in line with legislation and guidelines. Registered nurses and senior caregivers administering medications have completed annual competencies. The general practitioners review the medication charts at least three monthly.

Meals are prepared and cooked on site under the direction of a Food Service Leader. The menus are reviewed by a dietitian. The menu is varied and provides meal options. Individual and special dietary needs are catered for. Nutritious snacks are available 24 hours a day. Residents interviewed were very complimentary about 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 low risk.

The building has a current warrant of fitness. All rooms are single, personalised and some have ensuite facilities. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activities. The dining and lounge seating placement encourages social interaction. Outdoor areas are safe and accessible and provide seating and shade for residents. The dementia unit has space for residents to wander freely.

There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely, and the laundry is well equipped. The cleaning service maintains a tidy, clean environment. There is an emergency evacuation procedure. There is a first aid trained staff member on duty at all times.

Restraint minimisation and safe practice

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

Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had five residents using restraint and none using an enabler. Documentation reviewed identified safe implementation of restraint and regular review.

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. 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	0	43	0	3	4	0	0
Criteria	0	91	0	5	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training (link 1.2.7.4. and 1.2.7.5). Interviews with staff (eight caregivers, three-unit coordinators, three registered nurses, two housekeepers, one activity staff member, two kitchen staff, and the maintenance person) demonstrated their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident on all resident files reviewed. There was evidence of general practitioner (GP) completed and signed clinically not indicated resuscitation status. Family discussions were evident in progress notes documented by the registered nurses. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Signed admission agreements, enduring power of attorney and activation documentation was evident in the dementia resident files sampled.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups such as 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.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all compliments, complaints, both verbal and written, by using a complaint register (in hard copy and on RiskMan). There have been 15 concerns/complaints for 2019 and one complaint to date for 2020. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. Complaints follow-up was documented including toolbox talks to staff and one-on-one follow-up with staff as needed.</p> <p>Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, the clinical manager and registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>All five residents (two rest home level and three hospital level) and six relatives (two hospital, one rest home and three with a family member in 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.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans 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.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There were three residents who identified as Māori. One resident who identified as Māori praised the service; however cultural interventions were not well documented in care plans (link 1.3.5.2).</p> <p>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 and was last provided May 2019 (link 1.2.7.5). All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including residents' cultural beliefs and values, is used to develop a care plan with resident (if appropriate) and/or their family/whānau consultation.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. The 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, three hours a week. Policies and procedures meet current best practice and are readily available to staff.</p> <p>Links to hospice are very well documented including specialist input into end of life care. This was documented well in care plans reviewed. Fergusson won runner up to most improved care home in the Bupa awards, 2019.</p> <p>A room refurbishment programme is implemented and ongoing. Many rest home, hospital and dementia community rooms have been refurbished. A garden beautification programme is also in progress.</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. Ten accident/incident forms were reviewed from January and February 2020. 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.</p> <p>There are monthly resident and family meetings that promote open communication. An interpreter policy and contact details of interpreters is available.</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 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>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 Fergusson rest home and hospital is a Bupa residential care facility. The service provides care for up to 112 residents at hospital, rest home and dementia level of care. On the day of the audit there were 108 residents. There are 10 dual-purpose beds. On the day of audit, there were 51 rest home residents in the rest home wing and 40 hospital residents in the hospital wing. There were 17 dementia care residents. Hospital residents included; four younger persons under the younger person disabled contract, one ACC respite and one ACC permanent resident. There were two residents funded through the long-term support – chronic health conditions (LTS-CHC) contract, one at rest home level and one hospital. All other residents were under the age-related contract.</p>

		<p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. The care home manager provides a weekly report to the operations manager and there are monthly teleconferences to monitor progress of quality goals and to discuss issues.</p> <p>Bupa Fergusson is in the process of reviewing the 2019 quality goals and working with staff and head office to agree goals for 2020. The 2019 goals of reducing overall infections and empowering staff have been achieved. The staff empowerment goal was evidenced with the people pulse survey (2019) which documented a 71% favourable result and improved engagement from the previous year.</p> <p>The care home manager is a non-practicing RN. She has been in the role at Bupa Fergusson for two years and has had extensive management experience at Bupa. The care home manager is supported by a clinical manager who has been in the role since 2018. Staff spoke positively about the support/direction and management of the current management team.</p> <p>The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service, including attendance at a Bupa forum over three days, that covered business management, health and safety requirements and investigations and hazard management.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>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.</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</p>	<p>PA Low</p>	<p>Bupa has a comprehensively documented quality and risk system that has been partially implemented at Fergusson.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed at head office. New policies or changes to policy are communicated to staff.</p>

<p>improvement principles.</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, pressure injuries and wounds. Quality data is entered into the organisational RiskMan database where results are trended and compared with other comparable services.</p> <p>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. Action plans were not always documented as followed up and signed off.</p> <p>The service has a series of meetings in place, these include; quarterly staff meetings where operational issues are discussed, clinical review meetings twice a month for registered nurses (RNs) and discussion of residents at risk, monthly RN meetings, monthly infection control/health and safety meetings and monthly quality and risk meetings. Incidents and accidents were not always documented at meetings, infection control and restraint only reported numbers to meetings with no discussion.</p> <p>Staff interviewed confirmed they are required to read and sign meeting minutes.</p> <p>Annual surveys are completed with feedback analysed and corrective action plans developed for areas identified for improvement.</p> <p>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.</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 the immediate action noted and any follow-up action(s) required. Ten accident/incident forms for the month of January and February 2020 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. Incident/accident data is linked to the organisation's quality and risk management programme through Bupa head office, but not reported well through staff meetings (link 1.2.3.6).</p> <p>Discussions with the care home manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Appropriate notification was made around the outbreak during July 2019. Section 31 notifications were sent for three pressure injuries (all facility acquired).</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. Eleven staff files reviewed (one clinical manager, two registered nurses, two-unit coordinators, one activities staff, one cook, and four caregivers) evidenced implementation of the recruitment process and employment contracts. Agency nurse orientations reviewed were not all completed. Not all staff annual appraisals were up to date.</p> <p>A register of practising certificates including all health professionals involved in the service is maintained.</p> <p>The service has a comprehensive orientation programme in place that provides new (Bupa) 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.</p> <p>Eight caregivers work in the dementia unit. All eight caregivers have completed dementia unit modules.</p> <p>There is an annual education and a training schedule as well as education provided via toolbox talks. Not all education has been documented as provided according to the Bupa schedule, and with attendance being low, not all caregivers have achieved eight hours training over a year.</p> <p>Specific competencies are included according to the role such as medications, wound management, cardiopulmonary resuscitation and syringe driver for RNs. Six of twelve registered nurses are interRAI trained.</p>
<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>	<p>FA</p>	<p>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. Sufficient numbers of caregivers' support RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory and increased to manage resident acuity and occupancy. Staffing levels are as follows:</p> <p>Dementia unit (17 residents with 18 beds): morning shift - one RN/unit coordinator, two caregivers on full shift; afternoon shift – three caregivers on full afternoon shift (including one senior caregiver) and one caregiver on nights.</p> <p>Rest home (51 residents of 53 beds): morning shift - one RN/unit coordinator, four caregivers on full shift and two half shifts; afternoon shift – two caregivers on full afternoon and two until 9.30 pm (including a senior caregiver). One caregiver and one RN on nights.</p> <p>Hospital (40 residents of 41 beds); morning shift - two RNs and a unit coordinator, two RNs afternoon and one for the night shift; four full morning shift caregivers and four short shifts; afternoon six caregivers (two 3 pm - 11 pm, two 3 pm to 10 pm and two 4.30 pm to 8.30 pm). There are two caregivers and one</p>

		<p>RN at night.</p> <p>Activities staff are allocated to the rest home, hospital and dementia care unit.</p> <p>There are designated food services staff, cleaning and laundry staff seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The 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.</p> <p>Residents' files demonstrated service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and procedures in place to safely guide service provision and entry to services. Referring agencies establish the appropriate level of care required prior to admission of a resident. Information gathered at admission is retained in resident's records. Relatives interviewed stated they were well informed upon admission and had the opportunity to discuss the admission agreement with the manager. The service has a well-developed information pack available for residents/families/whānau at entry. An advocate is available and offered to family. The admission agreement aligned with the ARC contract. The eleven admission agreements viewed were signed. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>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. A transfer form and supporting documentation accompanies residents to the receiving facility and communication with relatives is documented by the registered nurse.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines</p>	PA Moderate	<p>There are comprehensive policies and procedures in place for all aspects of medication management. There were rest home residents self-administering on the day of audit, however, there was no documented competency on file. There are three medication rooms on site, all have secured key-pad access. There are two medication trolleys used in the rest home and hospital communities. Medication</p>

<p>in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>fridges had daily temperature checks recorded and were within normal ranges. All medications were securely and appropriately stored, however medication room temperatures have commenced daily. Registered nurses or senior caregivers who have passed their competency, administer medications. Medication competencies are updated annually and include syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There are no standing orders.</p> <p>The facility utilises an electronic medication management system. Twenty-two medication charts were sampled (eight dementia, eight hospital and six rest home). All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of PRN medication administered were documented in the electronic prescription. Controlled drugs and registers align with guidelines.</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 kitchen manager oversees the procurement of the food and management of the kitchen. The service is supported by one full time chef and two relieving cooks. All food services staff have attended food safety training. There are food service manuals and a range of policies and procedures in place to guide staff. There is a well-equipped clean kitchen and all meals are cooked on site. The main kitchen staff serve meals from the servery to the main rest home and hospital dining area. There is a separate dining room in the dementia unit. Meals are plated in the kitchen and delivered to the dementia unit and residents who wish to dine in their rooms via hot boxes. On the day of audit, meals were observed to be hot and well presented. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures are monitored and documented daily; these were within safe limits. The service has a current food control plan in place.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen by the registered nurse or unit coordinator. Special diets were noted on the kitchen noticeboard which is able to be viewed only by kitchen staff. The national menus have been audited and approved by an external dietitian. There was evidence that there are additional nutritious snacks available over 24 hours.</p> <p>A recent initiative was trailed in the use of black plates for meals in the dementia unit, six were trailed to start to see if this made a difference to the amount of food eaten. The trial was successful, and black plates were purchased for all the residents in the dementia unit, resulting in residents eating more at mealtimes.</p> <p>The kitchen manager attends resident meetings, and surveys provide feedback on the meals and food</p>

		service. Residents and relatives interviewed were very happy with meals provided and confirmed that alternative food choices were offered for dislikes.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency for appropriate placement and advice.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Bupa assessment booklets and LTCPs reviewed were comprehensively completed for all resident files reviewed. The assessment booklet provides in-depth assessment across all domains of care. The long-term resident files sampled evidenced information from the interRAI assessments and risk assessments were implemented and reflected into the care plan interventions. Overall, risk assessments are completed on admission and reviewed six monthly or when there is a change in residents' condition. Additional assessments for management of behaviour, wound care and restraint were appropriately completed as required.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	Care plans reviewed were comprehensive and demonstrated service integration and demonstrated input from allied health. The interRAI assessment process informs the development of the residents' care plan. Overall, resident care plans reviewed were resident centred and documented in detail, their support needs. Relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Relative communication and meetings were evidenced in the documentation reviewed. Long-term care plans in the dementia unit detail care and support for behaviours that challenge, including triggers, associated risks and management. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved. Staff interviewed reported they found the care plans easy to follow. There was evidence of service integration with documented input from a range of specialist care professionals. Psychogeriatrician, speech and language therapy, hospice, mental health services, physiotherapy and podiatry support and advice was evidenced and documented.
Standard 1.3.6: Service	PA	Registered nurses (RNs) and caregivers follow the care plan and report progress at each shift handover.

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>Moderate</p>	<p>The care plans reviewed did not always include all documentation to meet the needs of the residents and had been updated as residents' needs changed (link 1.3.5.2). If external allied health requests or referrals are required, the unit coordinators' initiate the referral (eg, wound care specialist, dietitian, or mental health team). Relatives interviewed stated that the clinical care is good and that they are involved in the care planning. Interviews with unit coordinators, registered nurses and caregivers demonstrated understanding of the individualised needs of residents.</p> <p>Caregivers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies (sighted). Specialist wound and continence advice is available by referral.</p> <p>There were 45 wounds on the day of the audit; eight skin tears in the dementia community (two residents), 14 skin tears and one chronic ulcer in the rest home (7 residents). The Lilac hospital community had; two grazes, seven skin tears, two surgical wounds, two chronic wounds (six residents), and three grade 2 pressure injuries (two residents). The Iris hospital community had two grazes, one incontinence dermatitis, one boil and one abrasion, and one unstageable pressure injury.</p> <p>Wound assessment, wound plans and evaluation forms and photos were in place, however, not all wound charts were completed as per best practice guidelines. Also, not all care plans had interventions around management of wounds and dressings (link 1.3.5.2).</p> <p>All residents with pressure injuries had appropriate care documented and provided, including pressure relieving equipment, however, monitoring charts were not always completed as instructed in the care plan. Access to specialist advice and support is available as needed. Care plans document allied health input.</p> <p>There was evidence of turning charts, monthly (or more frequent) weight and vital sign monitoring, food and fluid charts and behaviour charts in place. Unintentional weight loss has been discussed with the GP, and supplements were prescribed. Weight charts include % of weight gained or lost. No residents' files reviewed had met the criteria for referral to the dietitian.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a team of four activities coordinators that coordinate and implement the programme for each unit, all have current first aid certificates. The activities coordinators have received training around dementia care and needs. The programme is planned for five days. Suggestions of activities for caregivers in the rest home and dementia units to provide over the weekends, including music, walks, movies and one on one activities. The hospital unit has a seven-day programme. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. The monthly themed activities programme template is designed to cater for a range of cognitive, intellectual and physical needs. The monthly planner and weekly planner, which is displayed on noticeboards, is delivered to all residents' rooms each week.</p>

		<p>Residents have an assessment and map of life completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, family etc. Resident files reviewed identified that the individual socialising and activity plan is reviewed at least six monthly as part of the care plan review. The residents' activity care plans have de-escalating techniques for residents with behaviour that might challenge.</p> <p>Activities in the dementia unit include (but not limited to) newspaper reading, arts, crafts, baking/cooking, music, weekly church services, pet therapy, board games and weekly outings. One on one activities include walks in the garden, hand massages and reminiscing.</p> <p>Rest home and hospital activities are similar to those offered in the dementia unit, but also include entertainment, physical games, and a music therapist visits monthly.</p> <p>Community links are maintained with visiting church groups, outings to places of interest and picnics.</p> <p>The theme for the month of July was "shall we dance?" The residents and activities team organised the first mid-winter ball to be held at Fergusson. Entertainment was booked, residents were involved in making the invitations and decorations for the ball. Residents were dressed up in their finery for the occasion. Supper and drinks were provided, everyone who attended reported they "had a great time". A rock 'n' roll afternoon was held in January which the residents and visitors also enjoyed.</p> <p>The service receives feedback and suggestions for the programme through surveys, three monthly relative and resident meetings in all units. Residents and relatives interviewed spoke positively about the activities programme and team members. The service encourages younger residents to be as involved in facility activities as they wish. Younger residents are encouraged to maintain their links to the community. One resident is very independent and attends to their own activities within the community.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The files reviewed demonstrated that all interRAI assessments and care plans reviewed were not always evaluated at least six monthly (link 1.3.3.3) or when changes to care occurs. 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. All changes in health status are documented and followed up. The multidisciplinary review involves the RN, GP input, resident/family, unit coordinator and clinical manager. The files reviewed reflected evidence of relatives being notified of changes to care plans and reviews if not able to attend. In the files sampled care plans have been read and signed by the resident or EPOA/family. There is at least a three-monthly review by the medical practitioner. The residents and relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referral through the unit coordinators and specialist referrals are made through the GP. There was evidence of where a resident's condition had changed, and the resident was reassessed for a higher or different level of care. Discussion with the clinical manager and registered nurses identified that the service has access to a wide range of support either through the GP, Bupa specialists and contracted allied services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies related to chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. There is a secure sluice room in each area. All chemicals sighted were clearly labelled with manufacturer's labels and stored in locked areas in all services. Safety datasheets and product sheets are available. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. The staff interviewed were knowledgeable around the management of hazardous waste.</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>	FA	<p>The building holds a current warrant of fitness which expires on 16 November 2020. The maintenance person interviewed described the reactive and preventative maintenance that occurs. There is a 52-week planned maintenance programme in place. Electrical equipment has been tested and tagged. Hot water temperature is monitored weekly in resident areas and at hot water cylinders.</p> <p>There are four communities in the facility – Rainbow is the rest home level community, Lavender is the dementia community, and Lilac and Iris are the hospital communities. The corridors throughout the facility are wide, handrails are available to promote safe mobility. Residents were observed moving freely around the areas with mobility aids where required. There are areas to wander inside and outside with secure garden areas off the Lavender (dementia) unit. Residents are encouraged to bring in their own possessions and are able to adorn their room as desired. There are quiet, low stimulus areas that provide privacy when required.</p> <p>Staff interviewed stated there is sufficient equipment available to staff in all areas that is calibrated.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Eleven of 18 rooms in the Lavender (dementia) unit have toilet ensuites, there are communal toilets and showers situated close to resident rooms. The Lilac and Iris (hospital) communities have a mixture of rooms with either full ensuites, part ensuites (toilet only) or no ensuite facilities. Toilets shower facilities are situated close to rooms with no ensuite facilities.</p> <p>The Rainbow community has all rooms with shared toilet ensuites, and communal shower facilities. There are toilets situated close to communal areas in all wings.</p> <p>All have communal toilets and bathrooms are well signed and have privacy locks. All communal bathrooms allow for mobility equipment. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal, visitor and staff toilets are available and contain flowing soap and paper towels.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Resident rooms are spacious. Walking frames, wheelchairs and hoists can be manoeuvred around the bed within the rooms, if required. Residents requiring transportation between rooms or services can be moved from their room either by trolley or by wheelchair.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Activities occur throughout the facility in the lounge areas. The main open plan lounge/dining is centrally located in the centre of the Rainbow, Lilac, and Iris communities, and is used for activities and small groups as well as for private social interaction. Smaller seating areas are situated around the facility for more private conversations.</p> <p>The Lavender (dementia) unit has a spacious lounge area where activities are held with access to the secure garden. The separate dining room is spacious for residents to enjoy meals served from the kitchenette area through the servery. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.</p> <p>Seating and space are arranged to allow both individual and group activities to occur in all areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and</p>	FA	<p>All laundry is completed on site. There is a well organised laundry situated beside the front entrance. Laundry is transported from each area in closed line trolleys. There is only one door for entrance and exit and the two-laundry staff interviewed could describe how they maintain a “dirty” to “clean” flow. There are appropriate systems for managing infectious laundry, which laundry staff could describe. There is a</p>

<p>laundry services appropriate to the setting in which the service is being provided.</p>		<p>comprehensive laundry manual; cleaning and laundry services are monitored throughout the internal auditing system and the resident satisfaction surveys. The cleaners' trolleys were attended at all times or locked away in the cleaning rooms as sighted on the day of the audit. There is a sluice room in each community of the facility for the disposal of soiled water or waste. Personal protective equipment is available in the laundry and sluice rooms. Relatives and residents interviewed were happy with the laundry and cleaning services provided.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation attendance documentation was sighted. Fire training and security situations are part of orientation of new staff and are ongoing as part of the annual training plan. There are adequate supplies in the event of a civil defence emergency including food, backup battery power and gas barbeque, but insufficient supplies of water. Emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, toilets and showers and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The facility is secure after hours with security lighting and security patrols at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The facility is light and airy and able to be ventilated by opening external windows and doors. There is underfloor heating in the rest home and dementia units. Heat pumps heat the hospital areas. Internal temperatures are monitored and regulated by the maintenance manager. Residents in the rest home can adjust the temperature in their rooms.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and</p>	<p>FA</p>	<p>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 is 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 IC programme is reviewed annually. The infection control programme is implemented at Bupa Fergusson but not documented as reported at meetings (link 1.2.3.6).</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are</p>

scope of the service.		unwell. Residents are offered the influenza vaccine.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme. The infection control (IC) coordinator has maintained best practice by attending infection control updates through the Bupa IC consultant and on-line MOH course. The infection control committee is part of the Health and Safety committee (link 1.2.3.6).</p> <p>External resources and support are available through the Bupa quality & risk team, external specialists, microbiologist and DHB when required.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator 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 trend reviews through head office.</p> <p>Consumer education is expected to occur as part of the daily cares.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	FA	<p>The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p>

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff.</p> <p>Infections are entered into the electronic data base for benchmarking. Corrective actions are established where trends are identified. There has been one confirmed norovirus outbreak in July 2019. HealthCERT and public health were notified with ongoing correspondence during the outbreak period. Case logs and outbreak documentation was sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint is an agenda item at quality meetings (link 1.2.3.6). Documented systems are in place to ensure the use of restraint is actively minimised. There were five hospital level residents using restraints and no residents using an enabler (one was assessed for a bed rail enabler, but it was not in use at the time of audit).</p> <p>A registered nurse is the restraint coordinator. She understands strategies around restraint minimisation and assists with staff education around restraint minimisation. Staff interviews evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Education and competencies on restraint minimisation are scheduled annually.</p> <p>Three residents' files reviewed where a restraint was being used (bedrails) reflected an assessment and consent process had been completed with regular reviews. Residents using a restraint are monitored for safety.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (staff RN) 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.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>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. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. Three files for residents using restraints were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>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.</p> <p>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 three files reviewed.</p> <p>An internal restraint audit, conducted annually, monitors staff compliance in following restraint procedures.</p> <p>Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Staff were completing the monitoring forms accurately.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>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 as needed.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>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. Restraint numbers are discussed in meetings at Fergusson (link 1.2.3.6).</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Bupa Fergusson collects a variety of quality information including infection control, incidents and accidents, pressure injuries, falls, restraint usage and internal audits. The information is not always reported or discussed in meetings.	(i). Incidents and accidents are not consistently reported to meetings, including the quality and risk meeting for March, June and August 2019. (ii). The quality and risk meeting is also the resident minimisation meeting. The numbers of residents with restraint and enablers are reported, but there is no evidence of discussion around restraint minimisation or incidents associated with restraint (if any). (iii) The health and safety meeting is also the infection control meeting. Infection	(i). Ensure that incidents and accidents are reported to meetings. (ii). Ensure that restraint information is reported and the information reviewed with a view to reduce restraint and any issues from restraint discussed at the restraint meeting. (iii). Ensure that infection control statistics are reported at meetings and the trends and

			control results are reported at most meetings, but no discussion around infection control, trends, or initiatives. It was also noted that the July health and safety meeting was a copy of the May meeting.	implications of these results discussed at the infection control meeting. 90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	There is an implemented internal audit schedule in place. Where areas for improvement are identified, an action plan is documented. Not all action plans have been followed up and signed off.	The action plans resulting from internal audits have not all been followed up or signed off. This includes the internal audits for environmental nursing, environmental laundry, weight, moving and handling and clinical files.	Ensure that action plans following audits are followed up and signed off as completed. 90 days
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Moderate	There is a robust Bupa process for all staff, both permanent staff and temporary (agency), to complete an orientation/induction to services. This has not been implemented for agency staff.	Four agency nurse induction forms picked at random did not have a completed orientation/induction form.	Ensure that all agency nurses have an orientation induction completed as per Bupa policy. 60 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and</p>	PA Moderate	The Bupa human resource policies include guidance around annual appraisals and orientation/induction for all new staff (including temporary staff). These processes have not been fully implemented. There is a robust training schedule in place that covers all mandatory education. The attendance at training has not been high for all sessions and not all sessions have been provided (code of rights, advocacy and sexuality, as examples).	<p>(i) Six of eleven staff files reviewed did not have an up-to-date annual appraisal documented.</p> <p>(ii) Five caregiver education records reviewed did not evidence eight hours training in</p>	<p>(i) Ensure that staff have a documented annual appraisal.</p> <p>(ii) Ensure that staff attend at least eight hours education annually.</p>

effective services to consumers.		The manager has documented a process to catch up and this process has commenced.	the last year (iii) Not all education had been provided as per the Bupa schedule and attendance levels were low.	(iii) Ensure that all education is provided as per Bupa schedule. 90 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	There are competency assessments to be completed for all residents who self-administer medications; however, these have not always been completed.	Three of three rest home residents' self-administering medications do not have current medication competencies in place.	Ensure all residents who self-administer medications have a competency assessment completed. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Initial assessment booklets, interRAI assessments, and care plans were in place for resident in the files reviewed, however not always within expected timeframes.	i) One dementia and two rest home residents did not have an initial interRAI assessment completed within 21 days of admission. ii) The interRAI re-assessment was not completed within six months for one rest home resident. iii) One hospital resident (YPD) did not have initial assessments, or long-term care plan developed or reviewed within timeframes as identified in policy.	Ensure all assessments, and care plans have been completed and reviewed within expected timeframes. 180 days
Criterion 1.3.3.4	PA Low	Progress notes have been maintained according to policy by the caregivers using the format implemented mid-	i) There were gaps of up to 18 days in progress notes	Ensure progress notes reflect regular

<p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>		<p>2019. The registered nurses use stamps to identify their progress notes. The stamps have been used in the rest home and dementia communities to identify weekly reviews, and in the hospital files to identify 24-hour review, however, there was not always a written note by the RN.</p>	<p>documented by RNs on two dementia and two rest home files.</p> <p>ii) Two of four hospital files reviewed had a stamp only for a 24-hour review by the RN, however there was no written note/record.</p>	<p>RN assessment.</p> <p>90 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Overall, the interventions were individualised and reflected the level of care and assistance required by the caregivers. However, not all interventions were documented in the care plan. Caregivers interviewed described the care required for the residents they care for.</p>	<p>i) There were no interventions documented in the long-term care plan or wound chart around the management of the wound dressing, signs and symptoms of infection including MRSA, and maintenance of skin integrity or dietary requirements for two hospital level residents with long-term chronic wounds.</p> <p>ii) There were no interventions or side effects of warfarin was documented in the care plan of a rest home resident with fragile skin prone to skin tears.</p> <p>iii) There were no cultural interventions documented for a rest home resident who identifies as Māori.</p>	<p>i) Ensure care plans document information around management of wound dressings during personal cares, signs and symptoms of infection and maintenance of skin integrity are included in care plan interventions.</p> <p>ii) Ensure the side effects of anticoagulants are documented to alert caregivers to increased risk of bleeding and bruising.</p> <p>iii) Ensure all residents identifying as Māori have their preferences documented in the care plan.</p>

				180 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Wound assessments, plans and evaluations were documented for all wounds as sighted in the wound folders in each unit, however wound charts were not always completed in line with best practice. Photos are taken to evidence progression or deterioration. Pain assessments were completed before and after wound cares. Short term care plans were in place for all short-term wounds, long term chronic wounds were included in the long-term care plans.</p>	<p>i) Two wound assessments had more than one wound documented on the plan in two rest and two hospital level residents.</p> <p>ii) The turning chart was not maintained as per care plan interventions for a hospital level resident with an unstageable pressure injury.</p> <p>iii) Restraint monitoring was not completed according to policy in three of three restraint files reviewed.</p>	<p>i) Ensure only one wound is documented on each wound chart.</p> <p>ii) Ensure the turning chart is completed as instructed in the care plan.</p> <p>iii) Ensure restraint monitoring is completed according to policy.</p> <p>60 days</p>
<p>Criterion 1.4.7.4</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing.</p>	<p>PA Low</p>	<p>The service has at least three days of food stored, civil defence kits that are checked regularly, and has provided staff training. The water storage does not comply with DHB standard for water in the Hutt region</p>	<p>The service does not have sufficient water stored to comply with the civil defence requirement of 20 litres per person per day for seven days</p>	<p>Ensure the water stored for emergencies complies with the civil defence requirement.</p> <p>180 days</p>

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, 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

End of the report.