

Bupa Care Services NZ Limited - Rossendale Dementia Care Home & Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	Rossendale Dementia Care Home & Hospital
Services audited:	Hospital services - Psychogeriatric services; Dementia care
Dates of audit:	Start date: 21 January 2021 End date: 22 January 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	71



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Rossendale Home and Hospital is part of the Bupa group. The service provides psychogeriatric and dementia level care for up to 100 residents. On the day of audit there were a total of 71 residents.

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

Rossendale is currently being managed by an experienced Bupa interim manager and an experienced relief clinical manager. They are supported in their role by the wider Bupa senior regional and national teams.

An issues-based audit was completed 10 September 2020. Shortfalls identified at that audit were included as part of the scope of this surveillance audit.

One of the two shortfalls identified as part of the previous certification audit have been addressed. This was around water temperatures. Further improvements continue to be required around completion of the dementia standards.

This audit has identified improvements required around: complaints documentation, implementing the audit schedule and meetings, supervision, timeframes, care plan interventions, medication competencies, the external environment, access to external gardens for residents, emergency management and restraint management.

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.

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

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Family interviewed verified ongoing involvement with the community. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns are managed and documented and learning's from complaints shared with all staff.

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.

Services are planned, coordinated, and are appropriate to the needs of the residents. An interim care home manager and relief clinical nurse manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. An annual relative satisfaction survey is completed and there are regular relative newsletters.

Interviews with staff demonstrated a culture of quality improvements. An orientation programme is in place for new staff. There is an in-service training calendar in place. Registered nursing cover is provided 24 hours a day, 7 days a week.

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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The assessments and long-term care plans are developed in consultation with the resident/family/whanau. Long-term care plans are developed by the registered nurses and consider routines of residents.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing, and social interaction appropriate to the level of physical and cognitive abilities of the psychogeriatric and dementia care residents.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education, however medication competencies could be evidenced in all cases. The medication charts reviewed meet prescribing requirements and were reviewed at least three-monthly.

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. Choices are available and are provided, with nutritious snacks being provided 24 hours per day. The organisational dietitian reviews the Bupa menu plans.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Bupa Rossendale has a current building warrant of fitness. Protective clothing and emergency food supplies are available. The buildings are appropriately heated and ventilated. Bathrooms, personal space areas, and communal areas are suitable for resident's needs. There are processes in place to ensure a safe environment for residents, staff, and visitors within a secure environment. First aid training is provided to staff and is current.

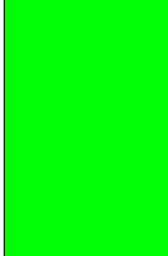
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		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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Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with training in restraint minimisation and challenging behaviour management. There are 27 residents in the psychogeriatric unit requiring the use of a

restraint and there are no residents requiring the use of an enabler. Restraints in use included 21 residents using occasional hand holding restraint and 11 with a lap belt. The service continues to actively minimise the use of restraint.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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. The service engages in benchmarking with other Bupa facilities. There have been no outbreaks.

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	9	0	1	10	0	0
Criteria	0	38	0	1	11	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>The complaints procedure is provided to relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation around investigations and service follow-up demonstrates that complaints are being managed and complainants informed. Of the seven complaints for 2020 two were staff complaints and two were linked to the advocacy and Health and Disability service. Three family complaints were documented as addressed, however there was no acknowledgement letter or formal outcome/resolution letter.</p> <p>Discussions with 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>There were two complaints that were being managed by the Bupa CSI team: One was through the Health and Disability service and the Advocacy service, and one was through the Advocacy service. Both have an action plan in place, and both remain open. Action plans documented follow-up and review on an ongoing basis.</p> <p>In response to the HealthCERT email dated 13 January 2021; related to a health and disability complaint the following has been evidenced.</p> <p>Rosendale has initiated a manual handling project for staff. The project included staff training and the appointment of manual handling champions. Although the champions have yet to be appointed, 100% of staff have attended manual handling training and have achieved the Bupa manual handling competency. This was achieved through</p>

		<p>providing manual handling training monthly from June 2020 to December 2020.</p> <p>Mealtimes were observed during the two days of audit; it was observed that staff were actively assisting residents as needed. Snacks were freely available and observed to be offered at all times of the day to residents (link to 1.3.6.1 as fluid charts were not consistently completed). The main kitchen has an up-to-date food control plan. The kitchen staff were aware of special diets and preferences for the residents. Walk arounds during the audit evidenced that there were no residents who were left with meals in their room and not provided assistance as needed.</p> <p>Staff were observed during two medication rounds and the process was observed to be safe, with staff observing and ensuring residents took the medication. Where the resident refused; the medication was taken away. Staff were able to explain that they offer the medication again later and/or document the refusal on the electronic medication chart (link to 1.3.12.3 as not all staff who administer medication have an up-to-date medication competency).</p> <p>The staff education data base evidenced that a high level of training has been provided, this has included personal hygiene – including continence care (May 2020), changes and reporting – including documentation (April 2020). There are four registered nurses who are interRAI trained (link to 1.2.7.5 as not all staff have completed the dementia unit standards within timeframes and staff appraisals were not up to date, 1.3.5.2 as care plan did not include all interventions and 1.3.6.1 as not all care interventions were evidenced).</p> <p>The service advised that mattress check had been undertaken, but this was not able to be evidenced (link 1.2.3.1).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The Bupa policies and procedures relating to accident/incidents, complaints and open disclosure are fully implemented. They 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. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms reviewed identified that family were kept informed. Five relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p> <p>Family/EPOA are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. The information pack is available in large print.</p> <p>Families/EPOAs of non-subsidised residents are advised in writing of their eligibility and the process for their family member to become a subsidised resident.</p>
Standard 1.2.1:	FA	<p>Rosendale Dementia Care Home & Hospital is part of the Bupa group of aged care facilities. The facility provides psychogeriatric (PG) and dementia level care for up to 100 residents. There were 71 residents at the time of audit</p>

<p>Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>including two residents in the 11-bed Totara dementia unit (under the ARRC contract) and 69 residents across the 89 PG level beds. The 69 residents at PG level care included six residents in the 10-bed high dependency unit, 27 residents in the 29-bed Kowhai PG unit, 14 residents in the 19-bed Rimu PG unit and 22 residents in the 31-bed Pohutukawa unit. There is a service plan to exit the dementia level service (Totara) and residents' have been transferred out, with the remaining two waiting for beds to become available. All residents were under the ARHSS contract except two funded through mental health services, one ministry of justice (all three in the PG units) and two residents in the dementia unit under the ARCC contract.</p> <p>The service is currently being managed by a Bupa interim manager. The interim manager has been in the role since July 2020 and is a very experienced Bupa manager. The manager is a comprehensive trained nurse with experience in working in mental health in the past. The manager is supported in her role by an experienced relief Bupa clinical manager. The relief clinical manager (CM) was the services quality partner prior to this and stepped into the role during November 2020 having been supporting the previous CM prior to this.</p> <p>The service management team are supported by; the operations manager who teleconferences at least weekly and visits often, the national quality support person for the Midlands region, a people partner for the region (human recourses) who has been on site two days a week to assist the interim manager and also Bupa continuous service improvements team members (CSI). On the days of audit, the Bupa dementia nurse specialist was on site assisting the service with setting up and implementing the Bupa mealtimes project. Senior team members from other facilities were also on site assisting the service with interRAI assessments.</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan.</p> <p>The interim care home manager and relief clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a hospital.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	<p>PA Moderate</p>	<p>A quality and risk management programme is documented. Interviews with the managers and staff reflected their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>An annual internal audit schedule was sighted for the service. Not all internal audits have occurred as per the audit schedule. However, corrective actions have been implemented when service shortfalls are identified and signed off when completed.</p> <p>RiskMan has been implemented by Bupa which is an electronic data collecting system. All incidents, complaints, infections, pressure injuries and falls are completed on the online system. The monthly collation of quality data</p>

<p>improvement principles.</p>		<p>includes (but is not limited to): resident falls; infection rates; complaints received; restraint use; pressure injuries; wounds; and medication errors.</p> <p>The Bupa quality programme includes a series of meetings. The meetings, such as staff and quality meetings have not always been held as scheduled. Clinical reviews have been held and document a review of resident conditions and care. Registered nurse and enrolled nurse meetings were introduced November and December (2020) and document an in-depth review of incidents and how to improve services. Daily stand-up meetings with heads of department include 'what's on today?', challenges, appointments, and activities (as well as any issues raised). The interim manager has credited the meeting with the service's move forward and enabling a leadership team. Meetings were witnessed on both days of audit.</p> <p>The service management team with the assistance of the national team(s) have implemented a series of action plans that include: improving clinical practice, reviewing staff scope of practice and ensuring staff are aware of their role, kitchen service improvement, activities for residents and environmental improvements. There are ongoing projects around staff fatigue management and shift management. Staff interviewed were aware of projects that pertained to their role.</p> <p>Falls prevention initiatives in place include: intentional rounding (link 1.3.6.1); sensor mats; post-falls reviews; physiotherapist assessment and recommendation; and individual resident interventions.</p> <p>An annual satisfaction survey is completed, and the 2020 results documented an improvement across all parameters since the previous year's audit except activities.</p> <p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There is a health and safety officer (household manager) who is supported by health and safety representatives. The Health and Safety committee team meet three-monthly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. The hazard register is reviewed regularly.</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</p>	<p>FA</p>	<p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. All incidents are coded in severity on RiskMan (severity 1-4) with 4 being the most severe. All resident incidents logged with a severity of 3 or 4 are automatically escalated to the Bupa CSI team immediately and the operations manager. Actions are then followed up and managed. Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a RN. Neurological observation forms were not documented and completed according to Bupa Policy for six unwitnessed falls with a potential head injury (link 1.3.6.1).</p> <p>A review of incident and accident data evidenced a rise in behaviours that challenge (and over the national Bupa</p>

<p>to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>national rate). Bruises had risen to over the national Bupa national rate, but have since reduced, falls have remained below the national Bupa rate as have pressure injuries. A spike in medication errors during August to November have reduced during December 2020. A series of action plans have been documented to address all issues.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been notifications made since the last audit for: one respiratory outbreak, one stage three pressure injury, one resident who left the service, one power outage, change of manager and one lack of RN availability.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There are human resources policies in place, including recruitment, selection, orientation, and staff training and development. Eight staff files (one-unit coordinator (RN), two RNs, one enrolled nurse and four caregivers) reviewed, evidenced implementation of the recruitment process, employment contracts and completed orientations. Annual performance appraisals were not all up to date. A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g., 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.</p> <p>The staff education database evidenced that a high level of training has been provided, this has included: manual handling (100% of staff), personal hygiene – including continence care (May 2020), changes and reporting – including documentation (April 2020). Falls prevention and pain management have also been provided as evidenced by staff interviews but the documentation was not able to be evidenced.</p> <p>Staff competencies were evidenced for chemical safety (household staff), the Bupa code of conduct, observing and reporting (100% of RNs), behaviours that challenge, complaints management, pressure injury care, cultural care, restraint, health and safety and infection control. The database alerts the manager when staff competencies are due. Not all staff had a medication competency (link 1.3.12.3).</p> <p>There are 47 staff that work across the PG and dementia units, 14 staff are new and have been enrolled on the dementia unit standards, however 33 staff continue to study towards achieving the required dementia standards, all have been employed over 18 months. The service continues to work towards compliance; however, this remains a shortfall from the previous audit.</p> <p>The service has worked to improve staff training, however the shortfall around training identified from the contract audit October 2020 have yet to be fully addressed.</p>
<p>Standard 1.2.8: Service Provider</p>	<p>PA</p>	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a relief care home manager and clinical nurse manager who both work full time from Monday to Friday. The care</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>Moderate</p>	<p>home manager and clinical nurse manager share the on-call duties on a fortnightly basis. Registered nurse cover is provided 24 hours a day, 7 days a week. Separate laundry and cleaning staff are employed seven days a week. Interviews with staff and family members identified that there have been concerns over staffing. The service has increased staffing since the previous audit.</p> <p>A review of the roster and following discussion with staff noted that a high level of agency staff is used. Advised, they try to use the same agency nurses as much as possible to achieve consistency of care. Agency nurses complete an agency nurse orientation. There were 52 agency shifts over the two-week roster reviewed. The use of agency has ensured that the staffing roster has been fully staffed for the two weeks reviewed. The service has implemented a staff fatigue management programme following feedback from staff. The use of agency is part of the fatigue management strategy to ensure staff do not work too many shifts. The service is actively recruiting for additional staff. Additional Bupa senior staff have also been assisting on site with interRAI assessments and staff support. The manager also actively follows up with staff following unplanned leave to ensure they are well.</p> <p>The PG beds are split into four separate units (Kowhai, Pohutukawa, Rimu units and the high dependency unit). There are two-unit coordinators who are supernumerary to the staffing. One for Pohutukawa and Rimu and one for Kowhai and the high dependency unit.</p> <p>The Kowhai PG unit has 27 of 29 residents. There is one RN on duty on the morning, afternoon, and night shifts. The RNs are supported by five caregivers on duty on the morning shift (four long and one short), five (four long and one short) on the afternoon shift and four caregivers on the night shift.</p> <p>The Pohutukawa PG unit has 22 of 31 residents. The Rimu PG unit has 14 of 19 residents. The two units share a roster and staff are allocated to the units. There is one RN on duty on the morning and afternoon shifts and one on the night shift. The RNs are supported by six caregivers on duty on the morning and afternoon shifts and four caregivers on the night shift.</p> <p>The high dependency PG unit has 6 of 10 residents. There is one RN on duty for each of the morning and afternoon shifts and one on the night shift. The RNs are supported by three caregivers on duty on the morning shift (two long and one short), three caregivers (two long and one short) on the afternoon shift and two caregivers on the night shift.</p> <p>The Totara dementia unit has 2 of 11 residents. Oversight is provided by the high dependency RN. There is one caregiver on duty for each of the morning shift, the afternoon shift and one caregiver on the night shift. The relief clinical nurse manager also provides RN hours in the dementia unit.</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>PA Moderate</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering due to the nature of the service. All legal requirements had been met for medication storage. There are no standing orders in use. There are no vaccines</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent caregivers administer medications. Not all staff have up-to-date medication competencies, however, there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperature are checked daily and were within acceptable limits. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twelve medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted. Records demonstrated that medications are administered as prescribed and the indication for use is documented for 'as required' medications. The effectiveness of 'as required' medications is entered into the electronic medication system and in the progress notes, this includes the effectiveness of PRN analgesia and could be evidenced in the records sampled. This is an improvement on the previous issues-based audit. Mental health team input into medication management and review was also evident. Medication rounds were observed in different areas and at different times and were seen to comply with all policy and legislative requirements.</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. All meals are cooked on site. The kitchen was observed to be clean and well organised and a current approved food control plan was in evidence. There is a four-week seasonal menu, which is reviewed by a dietitian at organisational level. A resident nutritional profile is developed for each resident on admission and this is provided to the kitchen staff by registered nurses. The kitchen is able to meet the needs of residents who require special diets, and the chef works closely with the registered nurses on duty. Lip plates are available as required. Supplements are provided to residents with identified weight loss issues. On the day of audit, meals were observed to be well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. Additional snacks are available at all times. Pre-made, moulded puree meals are available for those residents requiring diet modification. A family member expressed satisfaction in the visual appeal of the moulded puree food items. Staff were observed at mealtimes only assisting one resident at a time. Meals were trayed and delivered in hot box 's to the three dining areas.</p> <p>There is a food control plan expiring September 2021. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Resident files reviewed, and family interviews, identified that family were involved in the care plan development and ongoing care needs of the resident. The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. The range of resident files included (but not limited to) residents with high falls risk, suicidal tendencies, aggression, weight loss and unstable diabetes. For all resident files reviewed, the care plan documented interventions that reflected the interRAI assessments, however not all care plans reviewed had consumer-focused and integrated resident care solutions.</p> <p>Short-term care plans were utilised for acute health needs such as infections. Specific behavioural management strategies were included in care planning. Staff interviewed reported they found the plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Family interviewed expressed satisfaction with the level of care provided and this was also evidenced through the August 2020 family satisfaction survey. The general practitioner also expressed satisfaction in the hands-on care provided by staff. RNs and caregivers report progress against the care plan at least daily. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the wound specialist nurse). If external medical advice is required, this will be actioned by the GP. Communication with family is documented in progress notes and on the family communication sheet. Short-term care plans are available for use for changes in health status.</p> <p>Continence products are available and resident files include a urinary continence assessment. Specialist continence advice is available as needed and this could be described by the registered nurse. Care plans documented the continence care and support required for each resident including individualised toileting regimes, and continence products were available according to the continence plan. All residents observed on the days of audit appeared to have high levels of personal hygiene and no odour related to continence products, bedding or mattresses was noted. Residents were showered according to preference and need according to staff interviewed.</p> <p>Monthly weighs have been completed in all long-term files sampled. Referral to dietitian occurs as required, as confirmed in sampled files. Monitoring charts are in use for food and fluid intake; however, not all monitoring charts were documented according to the care plan instruction.</p> <p>Wound assessment, wound management plans and monitoring were in place for all identified wounds. This included twelve wounds in total, comprised of ten minor skin tears and two small lacerations. There were no pressure injuries at the time of audit. All wounds have been reviewed in appropriate timeframes and specialised wound management advice through the wound care specialist was not required for the current wounds, although registered nurses interviewed could accurately relate the referral process should this level of input be required. Dressing supplies are available, and the treatment room is stocked for use.</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 are two activity coordinators covering seven days per week who plan and lead all activities. They are assisted by caregivers based in each unit. Both activities coordinators are qualified diversional therapists. The activities programme operates seven days per week on a four-week rotating plan.</p> <p>On the days of audit residents were observed participating in activities.</p> <p>Residents are brought together from different units for group activities and those residents who prefer, have one-on-one activities including shopping trips, visits to coffee shops and other areas of the community (photos sighted). There are four levels of activity to guide staff as to which is most appropriate for a particular resident: active able, less active able, less active less able, and limited activity limited ability. The activity programme is further broken down into physical, cognitive, creative, and social activities.</p> <p>There are weekly outings, and the service utilises the facility van, and regular entertainers visit the facility. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as church groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan (link 1.3.3.3).</p> <p>Residents were seen to engage in the activity programme and enjoyed the entertainers present on the days of audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. The GP reviews the residents three monthly or when requested if issues arise or health status changes. The GP expressed satisfaction with the service and advised that nursing staff are prompt at informing of changes in the residents' condition and carry out instructions. Three resident care plans reviewed had not been evaluated by the registered nurses six-monthly or earlier if there was a change in health status (link 1.3.3.3). Activities plans are in place for each of the residents and these have been evaluated six-monthly.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p>	<p>FA</p>	<p>Click here to enter text</p>

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		
<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>	PA Moderate	<p>There is a building warrant of fitness displayed that expires 1 December 2021.</p> <p>A reactive maintenance and planned maintenance schedule are in place. There is a monthly checklist for planned maintenance including the calibration of medical equipment, functional testing of electrical equipment and hot water temperatures in resident areas. Hot water temperatures in resident areas are stable below 45 degrees Celsius.</p> <p>Residents were observed moving freely around the areas with mobility aids where required but not always supervised (link 1.3.6.1). The external areas and gardens were not well maintained, and residents did not have access to the gardens as the doors were locked. All outdoor areas have seating and shade.</p> <p>Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>	PA Moderate	<p>There is at least one staff member on duty at all times with a current first aid certificate. There are sufficient first aid and dressing supplies available. Emergency preparedness plans are accessible to staff and include management of all potential emergency situations. The service has implemented policies and procedures for civil defence and other emergencies. The service has civil defence resources and supplies. The service has an approved fire evacuation scheme. Fire evacuation training and drills was not documented as conducted six-monthly and fire notices were not in place. The service did not have directions for staff and visitors informing the name of the unit.</p> <p>Call bells were situated in all communal areas, toilets, bathrooms, and personal bedrooms. Residents were sighted to have call bells within reach during the audit. Where appropriate, sensor mats were also observed to be in use. The service has a visitor's book at reception for all visitors including contractors to sign in and out. Appropriate security systems are in place.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	FA	<p>The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are entered on RiskMan for all infections and analysed for any trends. The infection control officer (unit coordinator) completes a monthly report detailing any trends/analysis and corrective actions. Monthly data is reported to the monthly</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>combined infection prevention and control/health and safety meetings. Staff are informed of infection control through the variety of facility meetings and toolbox talks. There have been no outbreaks since the last audit.</p> <p>A Bupa companywide Covid strategy and pandemic plan was available to staff on site with education and associated resources relating to hand hygiene, PPE, and donning/doffing procedures.</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>There is a regional restraint group at an organisation level, which reviews restraint practices. The Quality Committee is also responsible for restraint review and use. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.</p> <p>There are 27 residents in the psychogeriatric unit requiring the use of a restraint and there are no residents requiring the use of an enabler. Restraints in use include 21 residents using occasional hand holding restraint and 11 with a lap belt.</p> <p>Not all restraint use is recorded on a restraint register. Files for five residents with restraint were reviewed. Assessments, consents, and monitoring is documented. All files evidenced that a documented one to two-monthly review of restraint has been conducted.</p> <p>One resident in the HDU was observed to be restrained in a room alone (a chair blocked her door) this resident had not been assessed for any restraint and the care plan did not document her care monitoring and support for this environmental restraint (link 1.3.5.2, 2.2.2.1).</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>PA Moderate</p>	<p>Bupa have comprehensive restraint policies and procedures in place. The policies are up to date and reflect best practice, with clear guidelines for restraint use minimisation. The policies have not always been followed.</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)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	Complaints reviewed all documented an investigation, and action plan as needed. The complaints log documented that complainants had been met with and/or telephoned. There were no formal acknowledgement or follow-up/resolution letters.	Three complaints received from family members during 2020 did not have an acknowledgement letter or a follow-up/closure letter on file.	<p>Ensure that the complaints process follows the formal Bupa policy/procedure.</p> <p>90 days</p>
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Moderate	Bupa has a comprehensive and well documented quality plan and process. This includes a schedule of meetings and also a schedule for internal audits. Not all audits have been undertaken as per the schedule and	(i). Not all audits have been completed as per schedule, this included: First impressions (June), activities (July), care planning, and emergency procedure (November). The clinical file	<p>(i). Ensure that internal audits are completed as per schedule.</p> <p>(ii). Ensure that mattress checks are scheduled</p>

		meetings have not always been held. T	<p>audit for September was commenced but not completed.</p> <p>(ii). The mattress checks required by the DHB have not been documented as implemented.</p> <p>(iii). Service meetings have not occurred as per the meeting schedule, this includes staff meetings (none since September). Quality meetings were evidenced only for June, July, and December.</p>	<p>and implemented.</p> <p>(iii). Ensure meetings are held to ensure communication of quality outcomes to staff</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>An annual education and training schedule have been completed for 2020 plus additional training. The service had provided further training as evidenced by staff interviews (such as person first training) and informal updates during handover, but these have not been documented. Dementia and PG unit standard training has continued but not all staff have completed within timeframes. Staff appraisals have not been kept up to date.</p>	<p>(i). There are 33 staff members who have been employed over 18-months who have not completed the required dementia unit standards.</p> <p>(ii). Staff appraisals were not up to date for five of five staff members who had been employed for over a year.</p> <p>(iii). Training such as falls prevention and pain management have been provided according to staff, but this has not documented as being completed.</p>	<p>(i). Ensure that all caregivers that work in the PG and dementia units have completed the required dementia standards within the required time as per the ARHSS and ARCC contracts.</p> <p>(ii). Ensure that staff have an annual appraisal.</p> <p>(iii). Ensure that all training is documented as completed</p>

				including falls prevention and pain management. 90 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>Interviews with staff and family members identified that there have been concerns over staffing. The service has increased staffing since the previous audit.</p> <p>A review of the roster and following discussion with staff noted that a high level of agency staff is used. Advised, they try to use the same agency nurses as much as possible to achieve consistency of care. Residents were seen to be left unsupervised in lounges for extended periods.</p>	<p>It was observed during the audit walk arounds that residents in communal areas are not always supervised</p>	<p>Adequately and consistently supervise vulnerable residents in communal spaces</p> <p>60 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>Medication training has occurred annually. However, not all medication competencies were up to date for all staff administering medications.</p>	<p>Not all staff (three registered nurses and three caregivers) who administer medications have an up-to-date medication competency.</p>	<p>Ensure all staff who administer medication have a current medication competency.</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p>	<p>PA</p>	<p>All six resident files reviewed</p>	<p>Four of five resident files</p>	<p>(i)-(iii). Ensure all</p>

<p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>Moderate</p>	<p>documented a care plan using the Bupa template. Long-term care plans and interRAI assessments were not completed within the required timeframes.</p>	<p>(under ARCCS/ARHSS contracts) showed long-term care plans and interRAI assessments were not always completed within the timeframes stated in policy. (i). Two new interRAI and long-term care plans were not completed within the timeframes stated in policy. (ii). Three routine interRAI and long-term care plans were not completed within the timeframes stated in policy. (iii). Three resident care plans reviewed had not been evaluated by the registered nurses six-monthly or earlier if there was a change in health status.</p>	<p>interRAI assessments and care plans are developed and reviewed within the required timeframes according to policy.</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>Each resident file reviewed included a care plan documented by a registered nurse. The care plans reflected family input to care using the comprehensive Bupa template. Not all care interventions were reflected into care plans including restraint and dietitian advise.</p>	<p>(i). Three of four PG resident care plans reviewed did not document the use of and the risks associated with using restraint or monitoring timeframes. (ii) One dementia resident care plan did not evidence the timeframes for blood sugar testing or the signs, symptoms and management plan for hypoglycaemia as advised by the dietitian.</p>	<p>(i)-(ii). Ensure all care plans evidence risks associated with restraint use and detail appropriate timescales for monitoring issues impacting resident care.</p> <p>90 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>There are a series of improvement plans centred around the safe and affective care for residents. The GP interviewed commented positively on the care provided within a complex environment. Monitoring charts were not completed in a timely, consistent, or comprehensive manner.</p>	<p>(i). Three of six resident charts showed neurological observations were not completed according to policy.</p> <p>(ii). Ten of ten fluid balance charts were not consistently or fully completed.</p> <p>(iii). Two resident positioning charts were not consistently completed.</p> <p>(iv). Restraint monitoring charts were not consistently or fully completed.</p> <p>(v). Four intentional rounding charts and behaviour monitoring charts were not fully completed or completed in a timely manner.</p>	<p>(i)-(v). Ensure all resident monitoring charts are fully completed in a timely manner and according to policy.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Moderate</p>	<p>There are outdoor areas for each of the units that provide a walking area. One external courtyard had uneven flooring, broken furniture, and potting mix accessible to confused residents.</p>	<p>(i). There was broken and uneven walking areas in one unit posing a trip hazard.</p> <p>(ii). There was broken furniture and potting mix accessible to confused residents causing a health and safety hazard.</p>	<p>(i). Ensure all outdoor areas are safe and that walking paths are well maintained.</p> <p>(ii). Ensure that hazardous substances are secured, and that broken and unsafe furniture is stored away from resident</p>

				areas. 60 days
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>PA Moderate</p>	<p>Each unit has access to an outdoor secure garden area. However, on the day of audit doors to external resident areas were found to be locked. Discussion with staff evidenced that this was to stop residents going outside unsupervised.</p>	<p>Residents were unable to freely access external areas.</p>	<p>Ensure all residents are free to access external areas at a time of their choosing.</p> <p>60 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	<p>PA Moderate</p>	<p>The service is in the process of general repainting and decorating. Up to date fire evacuation notices had been removed from walls to allow painting (painting still in progress in some areas during audit). This left some fire call point with no signage and some with very old signs that were securely fixed to wall & had presumably been covered by up to date signage before removal by painters). Same for other signage – removed to allow painting & had not been replaced at time of audit. Bupa requires that fire evacuations are practiced six-monthly, this was not documented as always occurring.</p>	<p>(i). Fire evacuation notices were not on walls above all fire call points where they were observed, they were out of date.</p> <p>(ii). There was no unit or directional signage to aid staff, residents and visitors should an emergency evacuation be necessary.</p> <p>(iii). There was no documented fire evacuation for the due date of September 2020.</p>	<p>(i)-(ii). Ensure fire evacuation notices and directional signage are in place in all areas of the building.</p> <p>(iii). Complete and evidence an emergency evacuation six monthly.</p> <p>60 days</p>

<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>	<p>PA Moderate</p>	<p>It was observed on the days of audit that one resident was confined to a room with a chair blocking the door. The staff informed that the resident required a calm environment and the need for a low stimulus environment was documented in the care plan. The resident was unable to leave the room due to a chair blocking the door. Staff described monitoring and care needs for this form of restraint the resident, however this was not documented and the restraint was not included in the restraint register and the resident had no assessment or consent documented.</p>	<p>One resident in the HDU was confined to a room (by a chair blocking the exit to the room). There was no assessment for this restraint and/or consent. This was not an approved form of environmental restraint.</p>	<p>Ensure that all residents with restraint have an assessment and consent according to Bupa policies. Ensure only approved forms of restraint are used.</p> <p>30 days</p>
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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.

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End of the report.