

# Bupa Care Services NZ Limited - Ascot Care House

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Bupa Care Services NZ Limited
<b>Premises audited:</b>	Ascot Care Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
<b>Dates of audit:</b>	Start date: 21 September 2021    End date: 22 September 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	75

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Ascot Care Home is part of the Bupa group. The service is certified to provide rest home, hospital (medical and geriatric), dementia and residential disability (physical) level of care for up to 104 residents. On the day of audit there were 75 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 a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management and a general practitioner.

The care home manager at Bupa Ascot care home is non-clinical and has been in the role for two years. She is supported by an experienced aged care clinical manager who has been in the role for one month. The management team are supported by the Bupa management team including an operations manager.

The Bupa systems, processes, policies and procedures are structured to provide appropriate care for residents.

This audit identified that improvements are required around communication of quality data, corrective actions following internal audits, mandatory education, staffing levels, incident and accident management, care plan completion and timeframes, handover for care staff, progress notes review, care plan updates and evaluations, controlled drug register checks 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.		Standards applicable to this service fully attained.
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Bupa Ascot Care Home endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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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A quality and risk management programme are established. Interviews with staff, and review of meeting minutes demonstrate a culture of quality improvements. Residents receive services from suitably qualified staff. Human resources are managed in accordance with good employment practice. 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, seven 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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There is an admission package available prior to or on entry to the service. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration. Resident files include three-monthly reviews by a general practitioner. There is evidence of other allied health professional input into resident care. Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner/nurse practitioner. An activities programme is implemented separately for the rest home, hospital and dementia residents. The programme includes community visitors and outings, entertainment and activities that meets the recreational preferences and abilities of the residents. All food and baking are done on site. All residents' nutritional needs are identified and documented. Choices are available and are provided. The organisational dietitian reviews the Bupa menu plans. Nutritious snacks are available in the kitchen for all units.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Some have shared and own ensuites. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe, secure and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is always on duty. The facility temperature is comfortable and constant. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Hot water temperatures are monitored.

## 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 low risk.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. At the time of audit there were seven residents using restraints. The approval process for restraint use includes ensuring the environment is appropriate and safe.

## 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 officer (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. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	42	0	3	5	0	0
<b>Criteria</b>	0	90	0	6	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location in English and in Māori. Policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and the training programme (link 1.2.7.5). Interviews with three managers (one care home manager, one clinical manager, one operations manager), twenty one staff (eight caregivers on the AM and PM shifts working across the rest home, hospital and dementia service levels; one staff registered nurse (RN); two unit coordinators/RNs; two enrolled nurses (ENs); two laundry staff; one kitchen manager, one cleaner, one maintenance officer, and two activities staff); and one contractor (dietitian) confirmed their understanding of the key principles of the Code and its application to their role and responsibilities.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information	FA	There is an informed consent policy. In all ten files sampled, three rest home, three dementia and four hospital (including one YPD), all had general consent forms signed and consent for van outings on file. Consent forms were signed and on file for flu and Covid vaccinations. Staff were knowledgeable around informed consent. Overall residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy. The medical resuscitation treatment plan and resuscitation advance directive are completed as soon as

<p>they need to make informed choices and give informed consent.</p>		<p>possible after admission. There is evidence of family/EPOA discussion with the GP for a medically indicated not for resuscitation status. In the files sampled, there is an appropriately signed resuscitation plan and advance directive in place. Discussions with residents and relatives demonstrated they are involved in the decision-making process, and in the planning of residents' care. Admission agreements had been signed and sighted for all the files seen.</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>	<p>FA</p>	<p>Information on advocacy support services is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support services. Staff receive education and training on the role of advocacy services (link 1.2.7.5).</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>	<p>FA</p>	<p>Residents may have visitors of their choice at any time, although during the Covid lockdowns, visiting hours have been restricted. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and helping ensure that they can participate in as much as they can safely and desire to do. Resident/family meetings are held monthly.</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>	<p>FA</p>	<p>The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using an electronic complaint register. Discussions with residents and relatives confirmed they are provided with information on complaints and complaints forms. Complaints forms are also located in a visible location at the entrance to the facility, next to a suggestions box.</p> <p>Two complaints have been received in 2021 (year-to-date) and were reviewed in detail. Both complaints reflected evidence of acknowledgement and an investigation. One complaint received on 31 August 2021 remains open and is under investigation. The second complaint has been documented as resolved and closed. Eleven complaints were received in 2020 and all these complaints are now documented as resolved.</p> <p>One complaint, lodged through HDC, was received on 24 April 2020. All requested information was forwarded to HDC, and an investigation has been completed. This complaint is now documented as closed. The corrective actions undertaken have included trialling a new fluids assistant (underway) and</p>

		<p>focussed staff education (2020) relating to fluid intake/urinary tract infections, managing the deteriorating resident and oral cares. Education was also provided to staff in 2020 on feedback and the complaints process.</p> <p>The Ministry requested follow up against aspects of the HDC complaint that included complaints management – communication with family, assessment - fluid balance management, Planning – fluid balance, pressure injury documentation and Service delivery/interventions – pressure injury preventative interventions. There were no identified issues in respect of this complaint.</p> <p>Staff are informed of complaints received via the monthly staff meetings, evidenced in the meeting minutes.</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 and/or clinical manager discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly resident/family meetings. Interviews with seven residents (four rest home and three hospital) and five relatives (three dementia, two hospital including one resident on a younger person with a disability (YPD) contract) confirmed that the residents' rights are being upheld by the service. Interviews with residents and relatives also confirmed their understanding of the Code and its application to aged residential care.</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, confirmed in interviews with care staff, residents and family, and during observations. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information are gathered on admission with family involvement and are integrated into the residents' care plans. Spiritual needs are identified. There is a policy on abuse and neglect, which is included in the in-service training programme for staff (link 1.2.7.5).</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</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 no residents who identified as Māori at the time of the audit. A Māori health plan is available for residents who identify as Māori.</p> <p>Māori consultation is available through the documented iwi links. A Māori music therapist visits the facility</p>

acknowledges their individual and cultural, values and beliefs.		twice monthly. Care staff interviewed confirmed that they are aware of the importance of whānau in the delivery of care for Māori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they are involved in developing the residents' plan of care, which includes the identification of individual values and beliefs. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.
Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Code of conduct training is also provided through the in-service training programme. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard.	FA	Registered nursing staff are available 24 hours a day, seven days a week. The residents retain their own general practitioner (GP). The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. Physiotherapy services are provided three days (six hours) per week. A podiatrist is on site every six weeks. The service has links with the local community and encourages residents to remain independent with examples provided (eg, a resident on the YPD contract is supported to assist with activities of daily living for the facility [eg, setting the table, serving residents], and a YPD resident is maintaining part time employment.)  Recent improvements in the care home have included a refurbishment of the internal courtyard in the dementia unit. This has been a significant project that took over 18 months to complete. It is a place that can be utilised in all seasons with turf laid to avoid puddles and mud patches and welcoming areas to sit and relax. A dementia support group has been established to educate and support families of their residents living with dementia.  Ascot received an Above and Beyond award in December 2020 in recognition of the delivery of personal protective stores to other Bupa facilities in the region (Gore, Riverton and Queenstown) during the first

		<p>Covid lockdown. A team of staff volunteered to support deliveries to the other sites.</p> <p>Ascot receives positive feedback on a consistent basis from families for the end-of-life care and support they receive from staff.</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>Policies and procedures relating to accident/incidents, complaints and open disclosure 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. Twelve accident/incident forms reviewed identified that family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes or following an adverse event.</p> <p>An interpreter policy and contact details of interpreters are available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>	FA	<p>Ascot Care Home is a Bupa aged residential care facility that is certified to provide care for up to 104 residents at hospital (geriatric and medical), rest home, dementia and residential disability levels of care. There are 40 dedicated rest home level beds, 40 dedicated hospital level beds and 24 dementia level beds. On the day of the audit there were 75 residents: 22 rest home, 37 hospital and 16 dementia. Two residents were on a residential disability (YPD) contract (one hospital, one rest home). The remaining residents were under the age-related residential care contract (ARCC).</p> <p>Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan and these goals are regularly reviewed.</p> <p>The care home manager (non-clinical) began employment at Ascot Park in May 2019. She has extensive management experience in the paramedic and aged care environments, primarily in Western Australia. The clinical manager has been in his role at Ascot Care Home for only six weeks. He has sixteen years of aged care experience including work at another Bupa aged care facility. Staff spoke positively about the support/direction provided by the new clinical manager, a position that had been filled the previous four months by an acting clinical manager.</p> <p>The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service.</p>

<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The clinical manager, who is employed full time, is the second in charge with additional support provided by the Bupa operations manager. Two unit coordinators support the clinical manager in his absence.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>The quality and risk management programmes are established but not embedded into practice. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.</p> <p>Interviews with the managers and staff reflected their understanding of the quality and risk management systems but there is a lack of consistency in the implementation of these systems. The monthly monitoring and collation of quality and risk data includes (but is not limited to) resident falls, infection rates, pressure areas, wounds, and medication errors. This data, its trends and the analyses of quality and risk data are available electronically (on RiskMan) but were not evidenced in staff meeting minutes as being regularly communicated to staff. Complaints received (if any) is a regular agenda item.</p> <p>An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. A selection of corrective actions resulting from the internal audits have not been documented as being implemented. Also missing is documented evidence of corrective actions being communicated to staff. Quality improvement forms are used to document improvement projects (eg, implementation of a trial fluid assistant, building and landscaping renovations to the dementia courtyard).</p> <p>An annual satisfaction survey is completed with the 2021 survey in progress at the time of the audit. The 2020 results in general reflect that the majority of residents (74%) would recommend the facility to others. A corrective action was implemented to address food satisfaction.</p> <p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. The health and safety team meet monthly with plans to move meetings to bi-monthly. A health and safety communication board lists the seven health and safety committee members and provides staff with health and safety updates. Staff and contractors undergo annual health and safety training which begins during their induction. The hazard register is reviewed regularly with the last review</p>

		<p>on 20 August 2021.</p> <p>Strategies are implemented to reduce the number of falls. This includes, (but is not limited to) ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding. Twenty-two sensor mats have been purchased to assist in reaching the 2021 annual health and safety goal of reducing residents' falls. For 2020 and 2021 (year to date) there have been three falls resulting in a fracture. Each serious injury (eg, fracture) as a result of a fall results in the clinical manager undertaking a root cause analysis (RCA) methodology for a clear understanding on how the fall could possibly have been prevented.</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>	PA Low	<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 (link 1.2.3.6 and 1.2.3.8). Incidents are coded in severity. All resident incidents logged with a high severity are immediately escalated to the Bupa head office and the regional operations manager.</p> <p>Twelve accident/incident forms were reviewed (pressure injuries, medication errors, falls (witnessed and unwitnessed)). Each event involving a resident reflected a clinical assessment and follow-up by a RN. Missing was evidence to indicate that the incident reports were reviewed and signed off by the clinical manager.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications made include: 2020: eleven pressure injuries, two outbreaks, one fire; 2021 (year to date) four pressure injuries, one coroner's inquest, two outbreaks, and one RN cover issue.</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>	PA Moderate	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Ten staff files reviewed (two unit coordinators/RNs, five caregivers, one cleaner, one housekeeper, one kitchen assistant) reflected evidence of implementation of the recruitment process, signed employment contracts and signed job descriptions. Performance appraisals are completed following the initial three months of employment and continue annually.</p> <p>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 and includes documented competencies. New staff are buddied with more experienced staff.</p> <p>There is an annual education and training schedule in place that addresses all required areas. In-services were trialled as a full day of (rostered) training, but implementation has been difficult due to staffing levels</p>

		<p>(link 1.2.8.1). In-services that do take place reflect very low staff attendance. There was evidence of only one (impromptu) toolbox talk taking place addressing personal protective equipment.</p> <p>Six of eight RNs (including the clinical manager) have completed their interRAI training.</p> <p>A competency programme is in place with different requirements according to work type (eg, support work, registered nurse, and cleaner). Core competencies are completed annually, and a record of completion is maintained. RN competencies include assessment tools, BSLs/insulin administration, CD administration, moving &amp; handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, CPR and syringe driver. RN competencies reviewed were up to date.</p> <p>Ten caregivers are employed to work in the dementia unit. Eight have completed the required dementia qualifications. One staff has recently been employed and will be completing hers. The remaining staff has been employed in the dementia unit for over 18 months and has not completed this required training.</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>PA Moderate</p>	<p>A policy is in place that determines staffing levels and skill mix for safe service delivery. Due to staff shortages (six full-time RN vacancies, two full-time EN vacancies, ten caregiver vacancies [six full time and four part time]), the staff roster is unable to provide sufficient and appropriate coverage for the effective delivery of care and support without the assistance of casual staff and permanent staff who are willing to extend their hours. Admissions are subject to being declined until staffing issues are resolved.</p> <p>The care home manager (non-clinical) and clinical manager are rostered Monday – Friday. Two unit coordinators/RNs are employed, one who covers dementia and one of two hospital wings and one who covers the rest home and one of two hospital wings. Both unit coordinators work Monday – Friday. During the audit, the clinical manager was planning to fill three night shifts on the upcoming roster with a significant number of rostered hours that were not yet filled.</p> <p>The two weeks (roster) before this audit were reviewed, with evidence of all shifts being filled by permanent and casual staff and staff extending their regular hours.</p> <p>Dementia (16 residents): AM shift: Either an RN or EN or senior caregiver is rostered with support provided by two long (eight hour) shift caregivers. PM shift: An RN or EN or senior caregiver is rostered with support provided by one long and two short shift caregivers, the night shift is rostered with one caregiver.</p> <p>Rest home (22 residents): AM shift: Either an RN or EN or senior caregiver is rostered with support provided by one long shift and one short shift caregiver. PM shift: An RN or EN or senior caregiver is rostered with support provided by one long and one short shift caregiver, the night shift is rostered with one caregiver.</p> <p>Hospital (37 residents): AM shift: one RN and either an RN or EN or senior caregiver is rostered with</p>

		<p>support provided by four long shift caregivers. PM shift: one RN and either an RN or EN or senior caregiver is rostered with support provided by two long and two short shift caregivers, the night shift is staffed with one RN and two caregivers.</p> <p>Residents and relatives stated that although their family member was well looked after, staff were observed as being very tired and overworked. Care staff also remarked on feeling tired and stressed due to the number of staff vacancies and high staff turnover.</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. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. Electronic files are backed up using cloud-based technology. Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is a comprehensive admission policy. Residents are assessed prior to entry to the service by the Needs assessment team. Specific information is available for residents/families/whānau at entry. Admission agreements align with the ARC contract, exclusions from the service were included in the admission agreement. The information pack includes all relevant aspects of the service. An admission agreement is signed either by the resident or EPOA, consent forms are discussed and signed, and an admission booklet is completed. All information gathered is kept in the resident's file. Of the ten resident files sampled, all had signed admission agreements and consent forms. All relatives interviewed felt they were fully informed of service provision and how to access services not included. All relatives felt they could refer to their admission pack.</p> <p>The care home manager and clinical manager screen admissions prior to entry to ensure a needs assessment has been completed and the service is able to provide the level of care required, if there is a room available. Due to current staffing level issues, the service is only taking admissions if they have sufficient staff to support additional residents. The clinical manager works closely with the local needs assessment team to manage this. The service operates 24 hours a day, 7 days a week.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>residents to receiving facilities and communication with family is made.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines with exception of controlled drug medication checks which have not been completed on a weekly basis. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the three medication treatment rooms. There was evidence of three-monthly reviews by the GP. Registered nurses, enrolled nurses and caregivers administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Temperature monitoring of the medication fridges and medication storage rooms were recorded daily and all within range. There were no residents self-administering medication on the day of audit. Twenty medication charts and administration records were reviewed, and all met acceptable best practice. 'As required' medications have reasons for giving documented and effectiveness is recorded by the registered nurses.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></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>There is a kitchen manager who oversees food management. The food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and there is a national menu in place that has been audited and approved by an external dietitian. There are policies in place to guide staff. All food is cooked on site in a large commercial kitchen. There is sufficient storage available. Stock rotation is practised. Hot food temperatures are monitored daily on all meals (records sighted). Fridges and freezers have temperatures monitored daily. Chilled inward goods are temperature checked on delivery and prior to storage. Daily air temperatures are recorded. Resident likes and dislikes are known, recorded in the kitchen and alternatives are offered.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes and is reviewed six-monthly, as part of the care plan review. Special diets (ie, soft and pureed diets) are noted on the kitchen noticeboard, which can be viewed only by kitchen staff. Meals are served from hot trolleys to the residents in the dining rooms and can be delivered to rooms as required. Specialist utensils and plates are available for residents. The resident annual satisfaction survey monitors food satisfaction. The kitchen is included in the internal audit programme. Staff have been trained in safe food handling and chemical safety. Residents and relatives interviewed commented positively on the meals provided. There are snacks and fruit, cheese and cracker platters available 24/7 in the dementia unit for residents.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is policy in place regarding the process for declining entry. Consumers are declined entry when there are no beds available or, if the person has health needs that are not able to be provided by the facility. Currently, the service is unable to take admissions due to staffing level issues. If a potential admission was declined entry, the consumer and where appropriate their family/whānau of choice, is informed of the reason for the decline and provided with other options where they can access services. The clinical manager works closely with the needs assessment team to facilitate other options for potential residents.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Comprehensive Bupa admission booklets which include risk assessments have been completed on admission in all files sampled. InterRAI initial and subsequent assessments have been completed, and printed copy of assessment summaries are evident in all ten files reviewed. Files reviewed in rest home, hospital, and dementia areas all had risk assessments completed on admission and reviewed six-monthly. Assessments such as wound, pain, behaviours and restraint were fully completed as resident need indicated. Information gathered from assessments is integrated in care plans in all ten files sampled.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed were comprehensive and included input from allied health as required. In all ten files reviewed care plans were individualised to resident need. Specific care plans are included and are reflective of resident need. Nurses complete transfer plans for residents with no mobility issues, otherwise these are completed by a physiotherapist. Short-term care plans are in place for acute episodes of care and resolved or transferred to long-term care plans in a timely manner. There is evidence of allied health input to care in care plans. Relatives interviewed were happy with the standard of care provided.</p> <p>Short-term care plans were in use for changes in health status and signed-off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care professionals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed</p>	FA	<p>Nurses and care staff follow the care plan and report against progress at each handover. Referrals to nurse specialists, dietitian and the like are discussed with the GP then activated by the RN. Medical referrals are actioned by the GP. There are adequate supplies of dressings and continence supplies available in all areas. Specialist continence advice is available if required. Wound assessments, management plans and evaluations were all fully completed.</p>

needs and desired outcomes.		<p>On the day of the audit, there were three rest home residents with wounds (bruise, cellulitis and a lesion); four dementia residents with six wounds (one head lesion, two skin tears, two stage one pressure injuries; ten hospital level residents with 20 wounds (three stage 1 pressure injuries, three stage 2 pressure injuries, one stage 3 pressure injury, three vascular ulcers, seven skin tears, and three bruises). Wound care plans include taking photos to assess progress and a wound specialist is available by referral.</p> <p>Interviews with RNs and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, restraint monitoring forms, turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. The dietitian was involved and residents were on protein supplements.</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>	FA	<p>The activities team at Ascot Care Home is comprised of one activities coordinator and one activities assistant who offer activities for residents five days a week. Both staff have first aid certificates and van competency completed. The activities coordinator has NZQA Level 3 qualifications and Level 4 dementia standards and is a DT in training; the activities assistant is enrolled in Careerforce to complete the dementia papers but has not completed them as yet. She has been employed less than 18 months. The service is currently trying to recruit a third activities staff member.</p> <p>The activity team have access to the Bupa diversional therapy (DT) team at head office. Each resident has an individual activities programme, which is reviewed when their plan of care is reviewed and as part of their interRAI assessments. The activity programme is implemented over five days per week in all three areas. Care staff have access to activities resources in the weekend. There are large open plan central lounge/dining areas which are used for activities for rest home and hospital. There are ranges of activities offered. There are separate rest home/hospital and dementia programmes with activities that meet the needs and preferences of the resident groups; however, some activities are integrated such as entertainment, as observed on the day of audit. Activities are provided in the dementia unit morning and afternoon Monday to Friday.</p> <p>Variations to the group programme are made known to the residents. Residents may choose to participate in any group programme. Individual programmes are delivered to residents in their rooms when they are unable to or choose not to participate in the group programme. The group programme covers physical, cognitive, social and spiritual needs. There are regular visiting entertainers and community groups. Targeted group programmes are offered as appropriate to meet the needs of subsets of residents. A weekly rotation of local churches come to provide church services. Residents can go on outings using the service's van, there is a local community van suitable for residents in wheelchairs which is utilised. Some rest home residents choose to use alternative transport arrangements to attend community interests. Residents have the opportunity to provide feedback on the activity programme through the bi-monthly resident meeting and resident satisfaction surveys. Residents and relatives interviewed were satisfied with</p>

		the activities programmes on offer.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Care plans reviewed had been evaluated by RNs; however, improvements are required in relation to amending a care plan when a change in level of care is conducted and following interRAI reassessments. Written evaluations reviewed did not always describe the resident's progress against the residents identified goals. Short-term care plans for short-term needs are evaluated and either resolved or added to the long-term care plan as an ongoing need. The six-monthly multidisciplinary review involves the RN, GP, activities staff, physiotherapist (if involved) and resident/family. The family are notified of the outcome of the review by phone call and if unable to attend, they receive a copy of the reviewed plans. There is at least a three-monthly review by the medical practitioner. The family members 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. 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, RNs and ENs identified that the service has access to a wide range of support either through the GP, Bupa specialists or 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 is an effective system of waste management in place. Chemicals are supplied by an external contractor and stored securely throughout the facility when not in use. Appropriate policies are available along with chemical product safety charts. Education on hazardous substances occurs at orientation and is included in in-service training. There is appropriate signage throughout regarding chemical storage and hazards. There is personal protective equipment available for use by staff and this was in use on the day of audit.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness, which expires 22 January 2022. The facility employs a full-time maintenance manager. There are proactive and reactive maintenance management plans in place. The grounds and gardens are maintained by a qualified gardener who assists with maintenance. Contracted providers test equipment. Electrical testing of non-hard-wired equipment was last conducted in May 2021. Medical equipment requiring servicing and calibration was scheduled for August 2021 but due to the Covid lockdown, was rescheduled for 29 September 2021. Hot water temperatures are checked on a weekly basis with resident taps maintained no higher than 45 degrees Celsius. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors to the facility.</p> <p>Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents are designated drivers. There are safe and secure garden areas in the dementia unit with seating and shade provided.</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>	<p>FA</p>	<p>There are adequate toilets and showers for residents. Some rooms have a shared ensuite. Some rooms are ensuite. Separate visitor and staff toilet facilities are available. Water temperatures are monitored, and temperatures are maintained at or below 45 degrees Celsius. Fixtures fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning.</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>	<p>FA</p>	<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>FA</p>	<p>There are several lounges throughout the facility and combined lounge/dining rooms. Residents can move freely. Activities occur mainly in the large rest home and hospital combined living/dining areas. There are quiet areas if people wish to speak privately. There is a café in the rest home lounge, so residents and</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>relatives can make their own beverages. Activities in the dementia unit occur in the lounge.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>A team of household staff managed by the full-time household supervisor cleans the facility. The household staff have access to the appropriate equipment and chemicals. Cleaning equipment and cleaning chemicals are stored securely when not in use. Laundry services are completed on site. Internal audits are completed to monitor performance. Household staff receive training at orientation and through the in-service programme. All housekeeping staff have completed chemical safety training and moving and handling and two have completed the Bupa dementia first training. There are policies in place to guide practice. Residents and relatives interviewed confirmed they were happy with cleaning and laundry.</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>FA</p>	<p>There are emergency/disaster management plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme (link 1.2.7.5). At least one staff member is on duty at all times with a current first aid certificate. Fire evacuation drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup.</p> <p>Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available. There are civil defence kits that are regularly checked. There is water stored to ensure a minimum of three litres per day for three days per resident.</p> <p>Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitor's book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. Access by public is limited to the main entrance.</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</p>	<p>FA</p>	<p>The facility is light and airy and able to be ventilated by opening external windows and doors. There is overhead electric heating. Internal temperatures are monitored and regulated by the maintenance manager. Residents interviewed were happy with the temperature.</p>

<p>at a safe and comfortable temperature.</p>		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<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 a senior registered nurse, and she is supported by the clinical manager and a clinical nurse specialist from the Southern DHB who works exclusively in aged residential care facilities. The committee and the Bupa governing body in conjunction with Bug Control, is responsible for the development of the infection control programme and its review. A lower north/southern regional infection control meeting addresses infection control issues across the organisation. The infection control programme is well established at Ascot Care Home. The quality/infection control committee consists of a cross-section of staff and there is external input as required from general practitioners, and local community laboratory. There is good access to public health service and hospital resource staff. The infection control nurse has attended external education by the DHB.</p> <p>Visitors are asked not to visit if they are unwell. Hand sanitisers were appropriately placed throughout the facility. The service has clearly defined Pandemic plans for Covid-19 alert levels and has procured sufficient supplies of PPE. Covid isolation kits have been put together in readiness, and education and training for staff has been provided. All visitors must register at reception and be screened. Covid vaccinations have been provided for staff and residents.</p>
<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>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Ascot Care Home. The infection control (IC) coordinator has maintained best practice by attending infection control updates. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control committee, training and education of staff and scope of the programme.</p>

<p>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>		
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. The infection control officer has received education by the Southern DHB, and Bupa education sessions to enhance her skills and knowledge. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice and group benchmarking.</p> <p>Staff have completed on-line training around infection control, and personal protective equipment (PPE) use. The infection control coordinator described the use of tool-box talks around emergent infection control issues, hand hygiene, and training around COVID and use of PPE. Infection control is discussed at all staff meetings.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and local laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control officer. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.</p> <p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the</p>

		<p>facility, hand hygiene and surveillance of infection control events and infections. Surveillance data including trends, analysis and corrective actions/quality are discussed at staff and clinical meetings.</p> <p>Infections are entered into the electronic database for benchmarking. Corrective actions are established where trends are identified.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the restraint coordinator, clinical manager and care staff confirmed their understanding of restraints and enablers. At the time of the audit, the service had seven residents using restraints and no residents using enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours with low attendance recorded (link 1.2.7.5).</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>	FA	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (staff RN) are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements. Staff training is scheduled two times per year (link 1.2.7.5). At the time of the audit, there were seven residents (five hospital, two dementia) using restraint and no residents using an enabler (link 2.2.3.4).</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>	FA	<p>The restraint approval process is described in the restraint minimisation policy. The roles and responsibilities for the restraint coordinator (RN) and for staff are documented and understood as evidenced in interviews with the restraint coordinator and care staff. Restraint processes identify the indications for restraint use, consent process, duration of restraint and monitoring requirements. In addition to staff training, staff are required to complete a restraint competency every year.</p>
<p>Standard 2.2.3: Safe Restraint</p>	PA Low	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments.</p>

<p>Use</p> <p>Services use restraint safely</p>		<p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Ongoing consultation with the resident and family/whānau are evident. At the time of the audit, five hospital level residents were using a restraint (four t-belts only and one bedrail and t-belt) and two residents in the dementia unit has 'as needed' hand-holding restraint.</p> <p>The files for two hospital level residents using t-belts as a restraint were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h). One of these residents was also using bedrails, which was documented in the resident's file as an enabler, and the enabler protocol was followed. The use of the bedrails was restraint that was requested by family. Monitoring of the resident while bedrails were in place was documented only once per shift, as required for an enabler, but not as required for a restraint.</p> <p>A restraint register is in place that is maintained by the restraint coordinator.</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). Evaluation has occurred three-monthly as part of the ongoing reassessment for the residents on the restraint register and as part of their care plan review, as evidenced in both residents' files reviewed. Evaluation timeframes are determined by risk levels.</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>Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the six-monthly regional restraint approval group teleconference meeting and information is disseminated throughout the organisation.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	The range of quality data collected is not routinely trended or analysed with results communicated to staff. Internal audits are completed as per the Bupa internal audit schedule but results that have associated corrective actions are not consistently communicated to staff in either the quality or the staff meeting minutes.	<p>i) A selection of quality data that is being collected and collated (eg, falls, skin tears, bruising) is not regularly trended, and analysed (evidenced once over twelve months).</p> <p>ii) Staff are not regularly kept informed regarding quality results (eg, the frequency of adverse events and internal audits completed each month and their results).</p>	<p>i) Ensure data that is collected is consistently trended and analysed.</p> <p>ii) Ensure quality data and internal audit results are communicated to staff.</p> <p>90 days</p>
Criterion 1.2.3.8	PA	Internal audits completed, reflect evidence of corrective actions where results are less than	Six of fourteen internal audits reviewed for 2021	Ensure corrective actions are reflected

<p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>Moderate</p>	<p>acceptable. Missing is evidence of these corrective actions being signed off to evidence their implementation.</p>	<p>were missing evidence of corrective actions being implemented (eg, laundry services, medication management, resident reviews, environment, cleaning, RiskMan).</p>	<p>as being implemented/signed off to indicate that they have been addressed.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>Adverse events are documented by staff electronically and include follow-up by a nurse. The adverse event is then delegated to the clinical manager for review. The recently appointed clinical manager (employed for six weeks at the time of the audit) has not signed off on a significant number of adverse events that took place in July and August 2021.</p>	<p>Thirty-three incident/accident reports (July and August 2021) are awaiting sign-off by the clinical manager.</p>	<p>Ensure each adverse event includes a timely review by the clinical manager.</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 Moderate</p>	<p>An education and training programme is developed by the Bupa head office that address all required areas. In addition to in-service training, staff complete a range of competency assessments. Staff education is not being completed as per the Bupa calendar. Attendance rates are very low and in-service training that is scheduled has often been cancelled due to staffing difficulties.</p> <p>Evidence of annual performance appraisals were missing in a selection of staff files. This has been identified as an area requiring improvement by the care home manager with a corrective action being implemented at the time of the audit.</p>	<p>i) Mandatory (annual) training is not being completed as per the Bupa training calendar. For those in services that take place, staff attendance is very low (below 50%).</p> <p>ii) One caregiver who has been employed to work in the dementia unit for over 18 months has not completed the required dementia standards.</p>	<p>i) Ensure the staff education and training programme is implemented as per the Bupa education and training calendar, and that staff attend all mandatory training.</p> <p>ii) Ensure all staff who work in the dementia unit complete the four required dementia standards within 18</p>

				months.  60 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>Staff turnover is high with 45 starters and 45 resignations in 2020 and 33 starters and 25 resignations in 2021 (year-to-date). In order to fill a roster, the care home manager is dependent on casual staff and staff working above and beyond their rostered hours. Interviews with the staff confirmed that they are very tired and burned out.</p>	<p>At the time of the audit, there were six full-time RN vacancies, two full-time EN vacancies, six full-time and four part-time caregiver vacancies. Recently six new care staff were employed. Of the six, five did not turn up for work. The remaining new care staff came for only two shifts and then failed to return. Due to the high number of staff vacancies, a staff roster cannot be built to meet staffing requirements and is highly dependent on casual staff and staff working extra shifts in order to provide adequate cover.</p>	<p>Ensure staffing levels are maintained to provide safe services to residents.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Controlled drug medication is entered into the register by the pharmacist and one registered nurse on delivery to the facility. A review of two controlled drug storage units evidenced that all medication was within expiry dates and all entries at the time of administration evidenced two signatures. Weekly checks of controlled drug medication had not been conducted routinely for either of the controlled drug registers reviewed. The hospital</p>	<p>Weekly checks of controlled drug medications have not been conducted.</p>	<p>Provide evidence that regular weekly controlled drug register checks are conducted.</p> <p>60 days</p>

		controlled drug register evidenced weekly records for the months of May, June and July 2021 and the rest home controlled drug register evidenced gaps in the register for January through to August. The clinical manager advised that he is aware of the previous record gaps and has taken steps to rectify this issue going forward. This was evident in the records for September.		
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA Low	The service employs registered nurses, enrolled nurses and caregivers. InterRAI assessments are completed by registered nurses. Enrolled nurses complete risk assessments, and care plans for rest home and dementia level residents. Two dementia level files reviewed evidenced registered nurse review and sign off of care plans	Enrolled nurses complete care plans for rest home and dementia residents. There is no evidence of registered nurse review and sign off in three rest home and one of three dementia files reviewed.	<p>Provide evidence that registered nurses have signed off care plans that have been completed by enrolled nurses.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	There are five registered nurses and the clinical manager who are competent to complete interRAI assessments for residents. InterRAI assessments have been completed within the required time frames for eight of the ten files reviewed. Long term care plans have been completed within 21 days of admission for eight of ten files reviewed. Care plan evaluations have been completed for eight of the ten files reviewed.	<p>i) InterRAI assessments have not been completed within 21 days of admission for two rest home residents; ii) long term care plans were not completed within 21 days of admission for one hospital and one dementia level resident; iii) six monthly care plan evaluations were not completed on time for one hospital and one dementia level resident.</p>	<p>i)-iii) Ensure that all aspects of assessments, care planning and evaluations are completed within the expected timeframes.</p> <p>90 days</p>

<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>The facility staff provides a handover of information between shifts for each area of service. A written handover template is available for staff to complete and oncoming staff can read this information. Registered nurses commencing the morning shifts receive a handover from the outgoing RN in the hospital and rest home areas at 6.45 am. Caregivers provide a verbal handover to incoming caregivers in the dementia units. Care staff commence their shifts at 7 am but do not always receive a handover in the rest home and hospital areas. Therefore, they are not receiving up to date information on the residents they are providing care to. Care staff interviewed confirmed that they do not always receive a handover due to the different shift start times. Progress notes are written in resident files every shift as evidenced in the ten files reviewed, however in the rest home and dementia areas, there is little evidence that registered nurses are reviewing entries by caregivers or enrolled nurses.</p>	<p>i) Caregiving staff commencing their shifts are not always provided with a verbal handover of resident information.</p> <p>ii) Progress notes reviewed for three rest home and three dementia residents do not evidence regular reviews by a registered nurse.</p>	<p>i) Ensure that all clinical staff receive a handover prior to commencing their shifts.</p> <p>ii) Provide evidence that registered nurses are reviewing progress notes for rest home and dementia unit residents.</p> <p>30 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>Ten resident care plans were reviewed. One rest home resident had not been at the service for more than six months therefore did not require a care plan evaluation. Two residents had recent changes in level of care; one resident had transferred from the rest home to the dementia unit, and one had transferred from the rest home to the hospital units. The hospital level resident had not had their care plan reviewed and changed to reflect their increased care needs. Evaluations had been completed on nine care plans by way of a registered nurse signing off</p>	<p>i) The long term care plan for one hospital resident had not been reviewed or amended following a change in level of care from rest home to hospital level.</p> <p>ii) Long term care plan evaluations did not indicate the degree to which goals had been met for one dementia resident, and one</p>	<p>i) Ensure that care plans are reviewed and amended when required to reflect all current care requirements.</p> <p>ii) Ensure that care plan evaluations address each aspect of the care plan.</p>

		on the front page of the care plan however, not all evaluations were completed for each aspect of the care plan to indicate the degree to which goals had been met. Five of the nine care plan evaluations had been completed after the interRAI reassessment.	hospital level resident. iii) Long term care plan evaluations had been conducted before the interRAI reassessment process, therefore had not informed the care planning evaluation for one dementia, two hospital and one rest home level residents.	iii) Ensure that long term care plan evaluations are conducted after interRAI reassessments in order to inform the care plan.  90 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the</p>	PA Low	One resident using a t-belt and bedrails had the t-belt documented as a restraint and the bedrails, requested by family documented as an enabler but it was a restraint.	One resident file reviewed included the use of a t-belt as a restraint and bedrails as an enabler. The restraint coordinator confirmed that this resident is unable to voluntarily request the bedrail to be released and was put in place as per family request. Use of the bedrails was assessed as a restraint/enabler with risks documented. The care plan identified that bedrails were required to be raised when the resident was in bed. Monitoring of this restraint took place only once per shift and was documented in the resident's progress notes. Evaluations had taken place three-monthly.	Ensure that the use of bedrails as a restraint is regularly monitored as per Bupa restraint policy.  90 days

evaluation of the restraint.				
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.