Bupa Care Services NZ Limited - Longwood Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Longwood Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 August 2017 End date: 24 August 2017

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: 42

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

Longwood Rest Home is part of the Bupa group. The service is certified to provide rest home and hospital level care for up to 52 residents. On the day of audit there were 42 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 general practitioner.

The care home manager has been in the role for three years. She is supported by a clinical manager who has been in the position for over three years.

There are quality systems and processes being implemented that are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to Longwood. Quality initiatives are being implemented which provide evidence of improved services for residents. There is an orientation and in-service training programme in place that provides staff with appropriate knowledge and skills to deliver care and support.

The service is achieving one continuous improvement rating relating to activities. One improvement having an up-to-date civil defence kit.

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.

Longwood 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 demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. 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. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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.		Standards applicable to this service fully attained.

Services are planned, coordinated, and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. Longwood is implementing the organisational quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. An annual resident/relative

satisfaction survey is completed and there are regular resident/relative newsletters. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. The staffing levels meet contractual requirements. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

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.		All standards applicable to this service fully attained with some standards exceeded.

There is a comprehensive admission package available prior to or on entry to the service. Resident records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. 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. An activities programme is implemented for the rest home and hospital 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 is 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 24/7 in the 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.		Some standards applicable to this service partially attained and of low risk.

Chemicals are stored securely throughout the facility. The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. 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 on duty at all times. 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. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty at all times.

Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place. At the time of the audit, the service had three residents using restraints and three residents with an enabler.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. 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. Staff receive ongoing training in infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	48	0	1	0	0	0
Criteria	1	99	0	1	0	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with 10 care staff (seven caregivers, two registered nurses and one diversional therapist), reflected their understanding of the key principles of the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There are established informed consent policies/procedures and advance directives. General consents obtained on admission were sighted in the residents' files reviewed. Advance directives if known were on the residents' files. Resuscitation plans for competent residents were appropriately signed. Copies of enduring power of attorney (EPOA) were in resident files for residents deemed incompetent to make decisions. An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Residents and relatives interviewed confirmed they have been made aware of and fully understand informed consent processes and confirmed that appropriate information had

		been provided. All resident files reviewed had a signed admission agreement.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held monthly and relative meetings bimonthly. Monthly newsletters are provided to residents and relatives.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint's register. One complaint made in 2016 and one complaint received in 2017 year to date, were reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed have been followed-up and implemented. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager, clinical manager and registered nurses (RN) discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Ten residents (five rest home and five hospital level) and four relatives (one rest home and three hospital level) interviewed, report that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff received training in July 2017. Young people with disabilities can maintain their personal, gender, sexual, cultural, religious and spiritual identity.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there was one resident that identified as Māori living at the facility. Māori consultation is available through the documented iwi links (Onaka Aparima Rumaka) and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic, last occurring in May 2017. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service 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 were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. 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. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. A house general practitioner (GP) visits the facility one day a week. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. The service receives support from the district health board (DHB). Physiotherapy services are provided on-site, six hours per week. There is a regular in-service education and training programme for staff. A podiatrist is on-site every six-weeks. The service has links with the local community and encourages residents to remain independent. Bupa has established benchmarking groups for rest home, hospital, dementia, psychogeriatric/mental health services. Longwood is benchmarked against the rest home and hospital data. If the results are above the benchmark, a corrective action plan is developed by the service. All Bupa facilities have a master copy of all policies and procedures and a master copy of clinical forms filed alphabetically in folders. These documents have been developed in line with current accepted best and/or evidence-based practice and are reviewed regularly. The content of policy and procedures are detailed to allow effective implementation by staff. A number of core clinical practices also have education packages for staff, which are based on their policies.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. 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 (from July 2017), identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and	FA	Longwood Rest Home is certified to provide hospital (medical and geriatric) and rest home level care for up to 52 residents. On the day of audit there were 42 residents in total, 20 rest home residents, including one resident on a long-term support chronic health condition contract (LTSCHC) and 22 hospital residents, including two residents under younger persons with disabilities (YPD) contracts and one resident on an ACC funded contract. All other residents are on the aged residential related care

appropriate to the needs of consumers.		(ARRC) contract. There are 18 dual-purpose beds between the rest home and hospital.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The clinical manager who is employed full time steps in when the care home manager is absent. The operations manager who visits regularly, supports the clinical manager.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	A quality and risk management system is being implemented into practice. Quality and risk performance is reported across facility meetings and to the organisation's management team. Discussions with the managers and staff reflected staff involvement in quality and risk management processes. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents' falls, infection rates, complaints received, restraint use, pressure injuries, wounds and medication errors. Quality and risk data, including trends in data and benchmarked results are discussed in the quality and applicable staff meetings. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are developed when service shortfalls are identified and signed off when completed. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrate a culture of quality improvements. Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. An employee health and safety programme (Smile) is in place, which is linked to the overarching Bupa national health and safety plan. There was an annual resident/relative satisfaction survey completed in March 2017 with a 100% overall satisfaction rate. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.

Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Individual reports are completed for each incident/accident, 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. Twelve accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations were completed for resident falls reviewed that resulted in a potential head injury. Incidents are benchmarked and analysed for trends. The managers are aware of their requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files (one clinical manager, two RNs, three caregivers, one cook and one maintenance officer) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. The caregivers when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this, they are then able to continue with Core Competencies Level 3, unit standards. These align with Bupa policy and procedures. Sixty-eight percent of the total staff have attained at least one Bupa personal best certificate. A total of 55% of caregivers have attained a Careerforce qualification. There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. Education and training for clinical staff is linked to external education provided by the DHB. There are six RNs and one has completed interRAI training with two enrolled for interRAI training on 28 August 2017. The care home manager and clinical manager are both interRAI trained. Core competencies are completed annually and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). There are a number of implemented competencies for registered nurses including insulin administration, moving & handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, syringe driver and medication competencies. Staff training has included sessions on privacy/dignity, and spirituality/counselling to ensure the needs of younger residents are met.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is an organisational staffing policy that aligns/includes skill mixes. Longwood has a four-weekly roster in place which ensures there are adequate staffing levels to meet the acuity and safety needs of the residents. The care home manager and clinical manager are available during weekdays. The care home manager is on-call after hours for any organisational concerns and the clinical manager is on-call for any clinical issues. Adequate RN cover is provided 24 hours a day, seven days a week. There is one RN on duty on the morning, afternoon and night shifts for the facility. In the hospital wing (16 hospital residents) there are four caregivers on duty in the morning shift, three caregivers on the afternoon shift and two caregivers on the night shift. In the rest home wing (12 rest home residents) there is one caregiver on duty in the morning and afternoon shifts. In the Oceanview wing (eight rest home residents and six hospital residents) there is one caregiver on duty in the morning and afternoon shifts. The caregivers in the hospital help in Oceanview if required. Interviews with residents and family members identify that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. 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.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The admission policy and resident information handbook outlines access, assessment and the entry screening processes. The local community and needs assessment and coordination agencies are familiar with entry criteria and how to access the service. The service operates 24 hours a day, 7 days a week. Comprehensive information about the service is made available to referrers, potential residents and their families, and sighted resident agreements contain all detail required under the aged residential care agreement. Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned	FA	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 residents to receiving facilities and communication with family is made. One file

and coordinated transition, exit, discharge, or transfer from services.		reviewed was of a resident that had been transferred to hospital acutely. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge, was well documented in progress notes.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Residents' medicines are stored securely in the medication room/cupboards. Medication administration practice complied with the medication management policy for the medication round sighted. There was evidence of three-monthly reviews by the GP. Registered 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 was recorded weekly. There were two residents self-administering medication on the day of audit, each had a competency completed by the GP, which was reviewed three-monthly or sooner if there is a concern, and kept in the medication file. Medication is kept in a locked box in the resident's room. There are standing orders, which were clearly prescribed. All are medication specific and can only be used for long-term residents.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a dedicated head cook 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. 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 whiteboard, which can be viewed only by kitchen staff. Meals are served from bain maries to the residents in the dining rooms and can be delivered to rooms as required. Specialist utensils and plates are available for residents. Alternatives are available and snacks are also available. The resident annual satisfaction survey monitors food satisfaction. The head cook goes around the units and asks the residents about their preferences as

		these often change from the first initial assessment. 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.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	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. 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.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Bupa assessment booklets and care plans were comprehensively completed for all the permanent resident files reviewed. InterRAI initial assessments and assessment summaries were evident in printed format in all seven resident files. Files reviewed across the rest home and hospital units identified that risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation. Additional assessments for management of behaviour, pain, wound care and restraint were appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed were comprehensive, and demonstrate service integration and input from allied health. All resident care plans sampled were resident centred. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Other specific care plans were implemented for specific health needs, including (but not limited to) dementia, depression, medical needs, diabetes, and chronic wounds. The contracted physiotherapist has completed transfer plans. Short-term care plans were in use for changes in health status and signed-off as resolved. There was evidence of service integration with documented input from a range of specialist care professionals.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	FA	Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan

desired outcomes.		of care. Wound assessment, monitoring and wound management plans were fully completed. On the day of audit, there were six wounds. These included three skin tears, one surgical wound, one excoriated area, one in-growing toenail. Interviews with registered nurses 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.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	The activity team at Bupa Longwood is comprised of one diversional therapist and four activity assistants who deliver the activity programme over seven days per week. 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 group activity programme is implemented over seven days per week in all areas. There is a large open plan lounge/dining area, which is used for activities for residents, additional to the lounge areas in the three areas. There are a range of activities offered. There are activities that meet the needs and preferences of the resident groups; however, some activities are integrated such as entertainment. 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. Residents have the opportunity to provide feedback on the activity programme through the bi-monthly resident meeting, discussion groups and resident satisfaction surveys. Residents and relatives interviewed were satisfied with the activities programmes on offer.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed had been evaluated by registered nurses six-monthly, or when changes to care occurs. Written evaluations reviewed described the resident's progress against the resident's 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.

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the clinical manager and registered nurses identified that the service has access to a wide range of support either through the GP, Bupa specialists or contracted allied services. YPD residents are assisted to access community groups and health services as needed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There is 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.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness, which expires 1 October 2017. The facility employs a part-time maintenance person. 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 August 2017. Medical equipment requiring servicing and calibration was last conducted in August. 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. 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 with first aid certificates and a full medical for driving.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	There are adequate toilets and showers for residents. Water temperatures are monitored and temperatures are maintained at or below 45 degrees Celsius. Fixtures fittings and flooring are

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.		appropriate and toilet/shower facilities are constructed for ease of cleaning.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	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.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are large lounges and dining areas in each area of the facility. There is an extra room that is multi-purpose, mainly used for some activities. Residents can move freely. Activities occur in each area as well as the multi-purpose room. There are quiet areas if people wish to speak privately.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The housekeeping 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. There is a good dirty to clean flow. Internal audits are completed to monitor performance. Housekeeping staff receive training at orientation and through the in-service programme. All housekeeping and laundry staff on duty on the day of the audit had a very good knowledge of outbreak management. There are policies in place to guide practice.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during	PA Low	There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. The facility has an approved fire evacuation scheme dated 30 May 2014. Fire evacuation drills take place every six months, with the last fire drill occurring on 28 July 2017. Smoke alarms, sprinkler system and exit signs are in place.

emergency and security situations.		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. There are civil defence kits in the facility, however, they were not up-to-date and had items that were past the expiry date. There is sufficient water stored to ensure for three litres per day for three days per resident. 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.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility is light and airy and able to be ventilated by opening external windows and doors. There is underfloor heating throughout the building. Internal temperatures are monitored and regulated by the maintenance person on a regular basis. Residents and relatives state the environment is comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme and its content and detail is 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 registered nurse (CM) and she is responsible for infection control across the facility. 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 Bupa Longwood. 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. On 1 August 2017, there was a suspected respiratory outbreak, all staff were updated with designated roles and responsibilities. Documentation in the IPC file evidenced the outbreak to be well managed with the relevant authorities having been notified. All samples sent for testing came back with no growth. A debrief and education session is planned to be held early September.

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at Bupa Longwood. 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. The IC coordinator has a 'glow bug kit' and regularly performs spot hand washing checks.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control committee, training and education of staff and scope of the programme.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand washing and standard precautions. Infection control training was last provided in July 2017. 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. A number of toolbox talks have been provided, including (but not limited to) multi drug resistant organisms and the importance of hand hygiene.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the	FA	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. 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

infection control programme.		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 coordinator. 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.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirm their understanding of restraints and enablers. At the time of the audit, the service had three residents using restraints (one bed rail and two lap belts) and three residents with bedrails as an enabler. Staff training around restraint minimisation and management of challenging behaviours was last completed in September 2016.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (care home manager) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	A restraint assessment tool is completed for residents requiring an approved restraint for safety. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations by the staff. Ongoing consultation with the resident and family/whānau are evident. The files for two residents using restraint and two residents using an enabler were reviewed. The completed assessment considered those listed in 2.2.2.1 (a) - (h). Falls risk assessments are completed six-monthly and interRAI assessment identifies risk and need for restraint.

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The care plan reviewed of two residents with restraint, identified observations and monitoring. Restraint use is reviewed through the three-monthly assessment evaluation, monthly restraint meetings and six monthly multidisciplinary meeting, which includes family/whānau input. A restraint register is in place providing a record of restraint use and is completed for residents requiring restraints and enablers.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). 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. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed at least monthly through the restraint meeting and as part of the internal audit programme. Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the regional restraint approval group teleconference meeting and information is disseminated throughout the organisation.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. There are civil defence kits in the facility, however they were not up-to-date and had items that were past the expiry date.	There was no up-to-date civil defence kit checklist. The civil defence kits reviewed were not up-to-date and had items that were past the expiry date.	Ensure that there is an up-to-date civil defence kit checklist and that all items are up-to-date. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	In 2016, the resident survey showed 50% of residents were dissatisfied with the activities programme. Activities staff was increased to cover 7 days a week. Residents and staff were involved with brain storming and decision making around the activities they would like to have on offer. Maintenance man has been booked to drive the van twice a week for outings. There has been an increase in training for activities staff. The activities 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. There is a walking group, which has been established for the more able residents, this has had a positive improvement in the fitness of residents and has shown a decline in falls (21 falls recorded in first quarter, 7 recorded in the second quarter). Some residents attend church services in the community, church services are	In 2016, the resident survey showed 50% of residents were dissatisfied with the activities programme. Activities staff was increased to cover 7 days a week. Residents and staff were involved with brain storming and decision making around the activities they would like to have on offer. Maintenance man has been booked to drive the van twice a week for outings. There has been an increase in training for activities staff. The activities 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. There is a walking group, which has been established for the more able residents, this has had a positive improvement in the fitness of residents and has shown a decline in falls (21 falls recorded in first quarter, 7 recorded in the second quarter). Some residents attend church services in the community, church services are

		held weekly in the facility, and the catholic priest visits on a weekly basis. Residents can go on outings using the service's van twice a week. The van can accommodate wheelchairs. Two activities staff go on outings. One drives and one is in the back with residents. At least one activities staff on outings holds a current first aid certificate, and has completed a medical to drive the van. One resident drives and has own car. The local school children come to the facility to 'adopt a grandparent' mornings and residents report they enjoy catching up with the children. Guest speakers included the CEO southern steel with the cup they won recently. One resident is very interested in woodwork. Activities sourced kit set trucks and other vehicles to assemble, one resident has a pet rabbit. The activities staff make a real effort to get to know all the residents and adapt the monthly programme around interests of the residents. There are raised beds to grow vegetables, spud in bucket competitions are held, and there is a knitting group. A childcare group attend the facility monthly. Activities staff are involved in the admission process around creating the 'map of life'. Special events are celebrated. With the changes in activities and increase in hours the satisfaction survey increased from 58% satisfaction in 2016 to 93% satisfaction in 2017	held weekly in the facility, and the catholic priest visits on a weekly basis. Residents can go on outings using the service's van twice a week. The van can accommodate wheelchairs. Two activities staff go on outings. One drives and one is in the back with residents. At least one activities staff on outings holds a current first aid certificate, and has completed a medical to drive the van. One resident drives and has own car. The local school children come to the facility to 'adopt a grandparent' mornings and residents report they enjoy catching up with the children. Guest speakers included the CEO southern steel with the cup they won recently. One resident is very interested in woodwork. Activities sourced kit set trucks and other vehicles to assemble, one resident has a pet rabbit. The activities staff make a real effort to get to know all the residents and adapt the monthly programme around interests of the residents. There are raised beds to grow vegetables, spud in bucket competitions are held, and there is a knitting group. A childcare group attend the facility monthly. Activities staff are involved in the admission process around creating the 'map of life'. Special events are celebrated. With the changes in activities and increase in hours the satisfaction survey increased from 58% satisfaction in 2016 to 93% satisfaction in 2017

End of the report.