Bupa Care Services NZ Limited - Whitby Rest Home & Hospital

Introduction

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

The audit has been conducted by 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:	Whitby Rest Home and Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 20 March 2018 End date: 21 March 2018

Proposed changes to current services (if any): As part of this audit the hospital unit was verified as suitable to provide hospital and rest home level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 88

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

Whitby Rest Home and Hospital is a Bupa facility that provides hospital (geriatric and medical), rest home, dementia and psychogeriatric level care for up to 98 residents. Occupancy on the day of audit was 88 residents in total. The service is managed by a care home manager who is a registered nurse. The care home manager has been in the role for seven months and has 14 years' experience of managing an aged care facility. She is supported by an experienced clinical manager who has been in the role for one year.

This unannounced surveillance 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, staff, management and general practitioner.

A vision, mission statement and objectives are in place. Annual quality/health and safety goals for the facility have been determined and are regularly reviewed by the care home manager.

The service has addressed three of six shortfalls identified at the previous audit around; incident form follow-up, medication documentation, restraint documentation in the resident care plans. Further improvements continue to be required around the quality system, fridge temperatures, and security of chemicals. This audit has identified improvements required around complaints documentation, training for caregivers in the dementia units, timeliness of care plan documentation, implementation of care, and medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.

Residents and family are informed, including of changes in resident's health. The care home manager and clinical manager have an open-door policy. Residents and relatives interviewed state the management and staff are very approachable should they have any concerns and are aware of the complaints process. There is a complaints policy and documented register.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. 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. Quality and risk performance is reported across the facility meetings and to the organisation's management team. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. There are human resources policies including recruitment, selection, orientation and staff training. An orientation programme is in place for new staff. The

organisational staffing policy aligns with contractual requirements and includes skill mixes. 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrated service integration and were reviewed at least six monthly. Resident files included medical notes by the contracted GP, and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies.

There is an activity team that deliver and coordinate the activity programme on-site for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each consumer group. Residents and families report satisfaction with the activities programme.

All meals ae prepared on-site.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

A current building warrant of fitness is posted in a visible location.

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.

There is a Bupa restraint policy that includes comprehensive restraint procedures including restraint minimisation. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were 14 restraints and three enablers being used.

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 surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	10	0	3	5	0	0
Criteria	0	36	0	3	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The complaints policy describes the management of the complaints process. There are complaint forms available at the entrance of the facility. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register. Twelve complaints (ten in 2017 and two in 2018) were. There were two complaints followed up by the DHB, as a result the service put in corrective actions around staffing/support, training, monitoring, and environment improvements. Not all complaints reviewed had documented evidence of the complaint outcome being communicated to the complainant or that the complainant was happy with the outcome.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	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. Twelve accident/incident forms reviewed identified family were kept informed. Four relatives (one rest home, one hospital, one dementia care and one psychogeriatric care) interviewed, confirmed that they are kept informed when their family member's health status changes. Seven residents (three rest home and four hospital) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. An introduction to

conducive to effective communication.		the dementia unit booklet provides information for family, friends and visitors to the facility.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Whitby Rest Home and Hospital is a Bupa facility that provides hospital (geriatric and medical), rest home, dementia and psychogeriatric level care for up to 103 residents. Occupancy on the day of audit was 88 residents. In the rest home unit there are nine beds with nine rest home residents (including two residents on respite). In the hospital unit there are 41 beds with 36 hospital residents (including one resident on respite) and two rest home residents. In the dementia unit there were 33 beds with 26 dementia care residents and in the psychogeriatric unit there are 15 beds with 15 psychogeriatric residents. At the time of the audit there were five beds in the psychogeriatric unit that were de-commissioned and not in use. The service does not have dual-purpose beds. As part of this audit the hospital unit was verified as suitable to provide hospital and rest home level care. A vision, mission statement and objectives are in place. Annual quality/health and safety goals for the facility have been determined and are regularly reviewed by the care home manager. A quarterly report is prepared by the care home manager and provided to the Bupa clinical service improvement team on the progress and actions that have been taken to achieve the Whitby Rest Home and Hospital quality goals. At the time of the audit Whitby Rest Home and Hospital was in the process of confirming the quality/health and safety site-specific goals for 2018. The 2017 goals were progress reported quarterly (in February, May, August and December). There were actions in place to achieve the goals, so they were met. The service is managed by a care home manager who is a RN. The care home manager has been in the role for seven months and has 14 years' experience of managing an aged care facility. The new care home manager has had both off site and on site structured orientation (which included specific dementia training with another care home manager). She is supported by an experienced clinical manager who has been in the role for one year. The management team are supported by one unit-coordinator, two registered nurse (RN) team leaders and a regional operations manager. All are experienced in dementia care and are supported by the Bupa dementia consultant. Care home managers and clinical managers attend annual forums and regional forums six monthly. The care home manager has maintained at least eight hours annually of professional development activities related to managing a hospital.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established,	PA Moderate	A care home manager and clinical manager are responsible for the day-to-day operations of the facility. Bupa has a documented quality system and process. The new management team at Whitby Rest Home and Hospital is in the process of ensuring implementation of the process. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. An annual internal audit schedule was sighted for the service; however, the internal audits were not completed for September and October 2017 and not all required corrective action plans have been completed or signed off. Riskman has been implemented by Bupa, which is an electronic data

documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		collecting system. All incidents, infections and falls are completed on the online system. Bupa Whitby collate data trends analysis and complete any action plans on any areas required for improvement (i.e., high falls, skin tears and UTIs). This is an improvement on the previous audit. Quality data information is discussed, at the staff, quality and clinical/RN meetings (e.g., complaints, infection control and incident/accidents) and the results are posted in the staffroom. However, not all quality, staff and clinical/RN meetings have been completed as per the meeting schedule. This is a continued shortfall from the previous audit. An annual satisfaction survey is completed, and 2017 results demonstrated a 73% positive outcome. Corrective actions were established in areas identified as below the national average, (i.e., around food/meals and activities). The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. The health and safety committee has been recently changed to have more representative membership, six representatives have received specific health and safety training in their role. The health and safety committee meet every three months. Staff undergo annual health and safety training which begins during their orientation. The hazard register is reviewed annually and was last reviewed in July 2017. 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 forms are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Twelve accident/incident forms were reviewed for February 2018. Incident forms reviewed reflected a clinical assessment, follow-up by a RN and identified ongoing assessment and evaluation by an RN post-incident. Neurological observations were completed for three resident unwitnessed falls that resulted in a potential head injury and documented according to Bupa timeframes. This previous finding has now been addressed. The service has implemented a corrective action around ensuring all bruising is photographed and sent to the facility and clinical managers who determine the action to be taken and check that an incident form has been completed. Data collected on incident and accident forms are linked to Riskman. The management team are aware of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications required since the last audit. An outbreak of Norovirus in May 2017 was managed, resolved and informed to the public health authorities.
Standard 1.2.7: Human Resource Management Human resource	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one clinical manager, one unit-coordinator, one RN (team leader), two caregivers, one cook and one activities coordinator), evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of registered nursing staff and other health

management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		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 caregivers when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. Health & safety training and manual handling has been regularly held to ensure all staff complete it. Education and training for clinical staff is linked to external education provided by the DHB. There are seventeen RNs and seven have completed interRAI training. There are a number of implemented competencies for RNs including (but not limited to) insulin administration, oxygen administration, PEG tube care/feeds, restraint, wound management, syringe driver and medication competencies. There are 14 caregivers that work in the dementia and psychogeriatric care units, six have completed the required dementia standards and two were in progress of completing. Six caregivers are yet to complete their dementia standards, three have been employed within the past 12 months and three have been employed for over 12 months.
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 with contractual requirements and includes skill mixes. There is a care home manager and clinical manager who both work full-time from Monday to Friday and share the on-call duties. The care home manager and clinical manager are supported by one unit-coordinator and two RN team leaders. Registered nurse cover is provided twenty-four hours a day, seven days a week. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. Separate laundry and cleaning staff are employed seven days a week. The facility is split in to four units; hospital unit (Kowhai) 41 beds, rest home unit (Totara) nine beds, dementia care unit (Rata) 33 beds and psychogeriatric unit (Kauri) 15 beds. There are 26 residents in the Rata dementia care unit. There is one RN (team leader) on duty on the morning shift and one RN on the afternoon shift. There are four caregivers on duty on the morning and afternoon shifts, and two on the night shift. In the Kauri psychogeriatric unit there are 15 residents. There is one RN (team leader) on duty on the morning and one RN on the afternoon and night shifts. There are three caregivers on duty in the morning and afternoon shifts, and one on the night shift. In the Kowhai hospital unit there are 38 residents (36 hospital and two rest home residents). There is one RN and one enrolled nurse (EN) on duty on the morning and on the afternoon shifts, and one RN on the night shift. There are seven caregivers on duty on the morning shift, six on the afternoon shift, and one on the night shift. There are nine residents in the Totara rest home unit. There is one RN on duty on the morning shift, the RN from the hospital covers the afternoon and nights shifts. There is one caregiver on duty in the morning and afternoon shifts, and one on the night shift.

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.	PA Moderate	Twelve medication charts were reviewed (four rest home including a respite, two dementia, four hospital and two psychogeriatric). There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicines are appropriately stored in accordance with relevant guidelines and legislation. The service uses an electronic medication system. The prescribing of medication meets legislative prescribing requirements. In the files sampled, all medication had a route charted. The medication charts reviewed identify that the GP has seen and reviewed the resident three monthly. The previous finding around GP prescribing and staff signing for administration has been addressed. This audit has identified new shortfalls around medication management including; documentation of allergies, photos on medication charts and medication round process. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role in regard to medicine administration. Standing orders are not in use. There was one resident self-medicating on the day of audit and all self-medication assessments, consents and reviews have been completed. The GP reviews the use of anti-psychotic medication and if required makes a referral to the psychogeriatrician. The medication fridge temperatures are recorded regularly, and these are within acceptable ranges.
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.	PA Moderate	The service employs four cooks and four kitchenhands. The Bupa national four weekly rotating summer/winter menus have been audited and approved by an external dietitian. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in bain maries and a hot box to each unit where they are served. The kitchen receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. End cooked food temperatures are recorded prior to placement in the bain marie or hot box. Fridges and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. A planned refurbishment of the kitchen was due to commence. On audit, all work surfaces were stainless steel and clean. Food service staff have completed on-site food safety education and chemical safety. There was no evidence that temperatures of the dementia servery fridges containing resident food, were monitored or recorded. Resident meals were stored in a (warm) cupboard. These plated meals were not dated or

		labelled. This is a continued finding from the previous audit.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	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 (e.g., to the district nurse [hospice nurse], or the mental health nurses). If external medical advice is required, this will be actioned by the GP or nurse practitioner. Not all nursing interventions were fully documented or implemented according to the care plan and or specialist direction. When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. There is documented evidence on the family/whānau contact form in each resident file that indicates family were notified of any changes to their relative's health. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Wound assessment, monitoring and wound management plans are in place for residents with wounds. Six wound care files were sampled (including two pressure injuries – both hospital) and all wound care documentation has been fully completed. All wounds have been reviewed in appropriate timeframes. The clinical manager described how to access specialist wound care advice.
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.	FA	The service employs five activity coordinators who continue to provide activities for all residents. The activity coordinators have all completed the dementia standards. All activity assessments and plans are completed by the activity coordinators in conjunction with the registered nurses. Activities are provided five days a week and activities are planned for weekends and after hours for the care staff to implement. There is a programme running in each of the four units (psychogeriatric, hospital, rest home and dementia) to meet the identified needs of the residents. This programme is printed for all (available throughout the facility and in individual bedrooms) and many activities are integrated with residents moving from unit to unit for some activities. Activity staff informed that the activity plans are flexible and are often adapted to the needs and wants of the residents on the day. Bupa has set activities on the programme calendar with the flexibility to add site-specific activities, entertainers and outings. Activities meet the abilities of all resident groups. One-on-one time is spent with residents who are unable to or choose not to join in the group activities. There is a wide range of activities provided including; visiting pets, kindergarten groups, school and cultural groups that reflect the culture of many of the residents. Residents go on regular outings and drives in the Bupa Whitby wheelchair hoist van. Residents are encouraged to maintain links with the community and some attend church services in the

		community. The family/resident completes a Map of Life on admission, which includes previous hobbies, community links, family, and interests. The individual activity plan is incorporated into the 'My Day My Way' care plan, and is reviewed at the same time as the care plan in all resident files reviewed. Residents/family have the opportunity to provide feedback on the activity programme through resident meetings and satisfaction surveys. Residents and relatives interviewed were overall happy with the activity programme. The two lounges in the dementia unit have been refurbished to provide a quiet space for residents and the second is a hobby room.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Files sampled for residents who had been in the service for over six months, demonstrate that the long-term care plans have been evaluated at least six monthly or earlier if there was a change in health status. There is at least a three-monthly review by the GP. All changes in health status are documented and followed-up (link 1.3.6.1). Reassessments have been completed using the interRAI assessment for all residents who have had a significant change in health condition. Short-term care plans sighted had not all been evaluated and resolved (link to 1.3.6.1).
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.	PA Moderate	There is a chemical/substance safety policy and waste management policy. Chemicals are stored safely in locked cupboards. Safety datasheets and product wall charts are available. Approved sharps containers are available and meet the hazardous substances regulations for containers. Management of waste and hazardous substances is covered during orientation of new staff. Chemicals were correctly labelled, and oxygen was stored securely and safely. This aspect of the previous audit shortfall has been addressed, however cleaner's trolleys were not always locked, and a sluice door was observed to be open. Chemical safety is a continued finding.
Standard 1.4.2: Facility Specifications Consumers are provided with an	FA	A current building warrant of fitness is posted in a visible location (expiry 25 June 2018). Since the previous audit the service has made some environmental improvements following a complaint. More linen and blankets have been purchased. More chairs, tables and curtains have been purchased to improve the look of the dementia unit and comfort for residents. Low couches have been removed and replaced with furniture that is easier to get in

appropriate, accessible physical environment and facilities that are fit for their purpose.		and out of. The two lounges in the dementia unit have been refurbished to provide a quiet space for residents and the second is being developed into a hobby room. The psychogeriatric lounge and quiet lounge have both been tidied up with appropriate fresh furnishings and curtains and improved access to the outdoor area with plenty of comfortable seating.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified, and quality initiatives are discussed at staff meetings (link 1.2.3.6). There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Systems in place are appropriate to the size and complexity of the facility A gastro outbreak during October 2017 was well managed and appropriate authorities informed.
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. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. There were ten hospital residents using restraint (four bed rails and six lap belts) and four psychogeriatric residents using restraint (two bedrails and two lap belts). Use of an enabler is voluntary; there were three hospital level residents with bedrails as an enabler.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are followed. An assessment form/process was completed for all restraints. An assessment for restraint/enabler use and consent form had been completed in two restraint (one hospital and one psychogeriatric) and one enabler (hospital) files reviewed. The care plans reviewed document the use of enabler or restraint and contain appropriate interventions. This is an improvement on the previous audit. Restraint education and audits have been completed. Monitoring forms that included regular two hourly monitoring (or more frequent). The service has a restraint and enablers register, which had been updated each month.

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 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	The complaints policy describes the management of the complaints process. There is a complaint register. Twelve complaints (ten in 2017 and two in 2018) were reviewed. Not all complaints reviewed had documented evidence of the complaint outcome being communicated to the complainant or that the complainant was happy with the outcome.	Ten complaints were made in 2017 and two complaints were received in 2018 year-to-date. Six complaints made in 2017 did not have documented evidence of the complaint outcome being communicated to the complainant or that the complainant was happy with the outcome/resolution.	Ensure that all complaint outcomes are communicated to the complainant and that the complainants are happy with the outcome. 90 days

Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Bupa has a robust documented quality system and process. The new management team at Whitby Rest Home and Hospital are working towards ensuring full implementation of the process. An annual internal audit and meeting schedule was sighted for the service. However, this has not been fully implemented. Bupa Whitby collate data trends analysis and complete any action plans on any areas required for improvement (i.e., high falls, skin tears and UTIs).	(i) Not all facility meetings have been completed according to the meeting schedule. There were two staff meetings and two quality meetings documented for 2017. Clinical/RN meetings did not always occur monthly in 2017. (ii) The internal audit schedule has not always been adhered to. Audits were not completed for September and October 2017. Eight out of sixteen corrective action plans required for audits not compliant, were not documented as completed or signed off.	(i) Ensure that facility meetings take place according to the meeting schedule. (ii) Ensure that the internal audit schedule is adhered to and that all required corrective action plans are completed and signed off. 90 days
Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	There is an annual education and training schedule being implemented. There are 14 caregivers that work in the dementia and psychogeriatric care units. There are three caregivers who have not completed their dementia standards that have been employed for over 12 months.	There are 14 caregivers that work in the dementia and psychogeriatric care units, six have completed the required dementia standards and two were in progress of completing. Six caregivers are yet to complete their dementia standards, three have been employed within the past 12 months. There was no documented evidence that the three caregivers that have been employed over 12 months had completed their dementia standards.	Ensure that all caregivers that work in the dementia and psychogeriatric care units have completed the required dementia standards. 90 days

Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	Bupa has policies in place to guide the safe and effective management of medication and documentation. Not all documentation was in place for individual charts and medication practice was not always according to policy.	(i)Hospital; three of four medication charts reviewed had no information documented around allergies, one of four had no photo. The controlled drug medication book has gaps in information, although stock count was correct. (ii) Dementia; two of two medication charts reviewed had no information documented around allergies. (iii) Rest home; one of four medication charts reviewed had no information documented around allergies, one of four had no photo. (iii) One respite resident; the charting times did not match the times on the blister pack (rectified on day of audit). The staff member did not take the respite prescription on the medication round; therefore, this issue was missed as the medication chart had AM medications and the blister pack did not.	(i)-(iii)Ensure that medication charts document allergies and have photo identification. Ensure that the controlled drug book is fully documented with no gaps. Ensure that the medication administration process follows Bupa policies. 30 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and	PA Moderate	Storage of food in the kitchen was in line with relevant standards and guidelines including the recording of the temperatures of fridges and freezers containing food. There was a shortfall in the servery areas where fridge temperatures were not recorded so evidence was lacking that food was safely stored.	There was no evidence that temperatures of the dementia servery fridges containing resident food were monitored or recorded. Three plates of meals were stored in the (warm) cupboard. These meals were not dated or labelled. Staff were unsure how long the plated meals had been in the cupboard.	Ensure all food is stored at the correct temperature and documentation reflects this. 30 days

guidelines.				
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Bupa has a templated assessment booklet and summary care plan for new residents. There are processes and policy around timeframes for all nursing and clinical documentation, however not all processes and documentation were fully completed within timeframes	(i)Two files for new long-term residents did not have an interRAI within 21 days (one of one rest home and one of one dementia). (ii) Initial assessments were not completed within timeframes for two long-term residents (one rest home of one and of one dementia); (iii) One resident did not have a long-term care plan completed within timeframes (one of one rest home)	(i)-(iii)Ensure that interRAI assessments, initial assessments and long-term care plans are fully completed within timeframes. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Care plans were in place in the files sampled, however they were not all fully completed and/or addressed all resident needs. Interviews with registered nurses and caregivers demonstrate an understanding of the individualised needs of residents but not all interventions were implemented according to clinical direction.	(i)One of two hospital files did not include all resident needs including; the use of a roho cushion for a resident with a sacral pressure injury, this resident was also observed sitting in the chair without the cushion. (ii) One hospital file had a range of short-term care plans (including weight loss, skin tears and a fractured femur). These care plans remained in the resident files but had not been evaluated or signed off once the issue had resolved. (iii)One psychogeriatric resident's file did not include all interventions and monitoring; examples include, behaviour monitoring, interventions to manage behaviours that challenge, management of weight loss and process to give sedation prior to care as directed by the nurse specialist. (iv) One dementia file did not include all interventions to manage all assessed needs, example include; interventions to manage behaviours that challenge and wandering, and the summary care plan was not fully complete. (v) One of two rest home resident's files did not include all interventions to manage assessed needs, examples include; the risk of wandering and interventions needed. (vi) In the psychogeriatric unit the practice is to raise beds during the day to prevent residents going to bed	(i)- (v) Ensure that care plans are fully completed and that interventions to manage are documented and implemented. Ensure that short-term care plans are evaluated and signed off when the issue is resolved. (vi) Ensure that

			(their own or other's beds)	residents have autonomy to return to their beds if they wish to. 30 days
Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.	PA Moderate	There are policies and procedures in place to ensure the safe use and storage of chemicals, and staff have received training. Not all chemicals were securely and safely stored.	The cleaner's trolleys were observed to be unlocked and unattended on day one of the audit in the dementia unit and the psychogeriatric unit. On day two, the sluice in the hospital wing was left open (where chemicals were stored).	Ensure that chemicals are stored safely and securely. 30 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.

No data to display

End of the report.