Bupa Care Services NZ Limited - The Booms Home & Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	The Booms Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 August 2018 End date: 30 August 2018

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 65

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

Bupa The Booms Care Home provides rest home, hospital and dementia levels of care for up to 69 residents. There were 65 residents during the audit.

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

The care home manager is a registered nurse who is appropriately qualified and experienced and is supported by a clinical manager/registered nurse. There are quality systems and processes being implemented. Feedback from residents and families was very positive about the care and the services provided. Induction and in-service training programmes are in place to provide staff with appropriate knowledge and skills to deliver care.

There was one area of continuous improvement around reducing the number of residents' falls in the rest home.

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.

The service complies with the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights. Staff strive to ensure that care is provided that focuses on the individual resident, values residents' autonomy and maintains their privacy and choice. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed appropriately and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The care home manager is supported by administrative staff, a clinical manager, registered nurses, caregivers and support staff. Quality activities generate improvements in practice and service delivery. Monthly staff meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored via annual satisfaction surveys. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

A comprehensive education and training programme is implemented with a current plan in place. Appropriate employment processes are adhered to. There is a roster that provides sufficient and appropriate staff cover for the effective delivery of care and support.

The residents' 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. Residents' files are protected from unauthorised access.

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.		Standards applicable to this service fully attained.

There is an admission package available prior to or on entry to the service. 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 input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner/nurse practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP/nurse practitioner (NP).

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on-site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents were satisfied with the meals and commented positively on the baking provided. There are snacks available at all times.

Safe and appropriate environment

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

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current building warrant of fitness. There are some rooms with ensuites and there are sufficient numbers of communal showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

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. There were two residents using bedrails as restraints and seven residents who were identified as needing hand holding intermittently as a restraint during their cares. Four residents were using enablers. A registered nurse is the designated restraint coordinator. Staff are provided with training in restraint minimisation and challenging behaviour management, which begins during their orientation. Staff are expected to complete a restraint minimisation competency every year.

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. A registered nurse is the infection control coordinator who is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There were two reported outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	1	100	0	0	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's (HDC) Code of Health and Disability Consumers' Rights (the Code) policy and procedure is implemented. Discussions with the care home manager, clinical manager/RN, and thirteen staff (four caregivers who are responsible for all three levels of care (rest home, hospital and dementia), four RNs, one activities coordinator, one cook, one laundry, one cleaner, one maintenance) confirmed their familiarity with the Code and its application to their job role and responsibilities. Interviews with nine residents (six rest home and three hospital) and three relatives (one hospital, two dementia) confirmed that the services being provided are in line with the Code. The Code is regularly discussed during staff meetings and resident meetings.
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	FA	The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident on all resident files reviewed (two rest home, four hospital and three dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney evidence is filed in the residents' charts and every dementia file reviewed had a completed form.

give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There is a policy that describes the role of advocacy services. Staff receive training on advocacy. Information about accessing advocacy services is available in the information presented to residents and their families during entry to the service. Advocacy support is available if requested. Interviews with staff, residents and relatives confirmed that they were aware of advocacy services and how to access an advocate. The complaints process reminds the complainant of their right to contact the health and disability advocacy service with contact details provided. During the audit, an advocate from the community was observed meeting with a resident.
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 are encouraged to be involved in community activities and maintain family and friend networks. Care staff interviewed confirmed that residents are encouraged to build and maintain relationships. Visiting can occur at any time. Community links were evident and included (but were not limited to) local churches, hospice, aged concern, and local clubs.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy describes the management of the complaints process. Complaints forms are available at the entrance to 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. A complaints register is maintained. Three complaints have been received in 2018 (year to date) and all three complaints were reviewed. Each verbal or written complaint included an investigation, met expected timeframes and corrective actions were put into place where indicated. Complaints are linked to the quality and risk management system. All three complaints had been signed off as resolved. Discussions with residents and families confirmed that issues are addressed promptly and that they feel comfortable to bring up any concerns with the care home manager and/or clinical manager.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are	FA	There are posters displaying the Code in English and in Māori. The service is able to provide information in different languages and/or in large print if requested. On entry to the service staff discuss the Code with the resident and the family/whānau. Written information on the Code is provided in the information pack to the resident, next of kin or enduring power of attorney (EPOA) to read and discuss.

informed of their rights.		
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	The service has policies which align with requirements of the Privacy Act and Health Information Privacy Code. During the audit, staff demonstrated gaining permission prior to entering residents' rooms. All care staff interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents' cares. A recent initiative by one care staff included signage that is placed outside of a resident's room when cares are being provided. Residents and family members interviewed confirmed that staff promote the residents' independence wherever possible and that residents' choices are encouraged. There is an abuse and neglect policy that is implemented, and staff have undertaken training on abuse and neglect.
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 has established Māori cultural policies to help meet the cultural needs of its Māori residents. Bupa has developed Māori Tikanga best practice guidelines, which are posted in visible locations. The service has established links with local Māori advisors. Staff training includes cultural safety. Māori staff bless residents' rooms following a death. The resident's cultural needs are assessed and documented in their care plans. There were four Māori residents, one who was interviewed. This resident confirmed that their cultural needs were being met by the service.
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 has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that the residents' cultural and individual values were being met. Information gathered during assessment including residents' cultural beliefs and values are used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on (sighted in one file of a resident who identified as Māori). Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. There were no residents at the facility who did not understand or speak English.

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, evidenced in the ten staff files reviewed. Professional boundaries are defined in job descriptions. Interviews with staff 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. The service receives support from the district health board, which includes visits from specialists (eg, geriatric nurse specialist (GNS), mental health services) and staff education and training. Physiotherapy services are provided for four hours per week. There is a robust education and training programme for staff that includes in-service training, impromptu training (toolbox talks) and competency assessments. The activities programme is provided to rest home, hospital and dementia level residents seven days a week. Podiatry services and hairdressing services are provided. The service has links with the local community and encourages residents to remain independent.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	All residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. A record of communication with families is retained in each resident file. The accident/incident form includes a section to record family notification. Ten incidents/accidents reports reviewed electronically on Riskman indicated family were informed. Families interviewed confirmed they are kept informed of any changes in their family member's health status. One complaint was lodged in 2018 around communication with families with evidence of corrective action taken including a toolbox talk with staff.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated,	FA	The Booms Home and Hospital (The Booms) is owned and operated by Bupa Care Services NZ. They provide rest home, dementia and hospital (medical and geriatric) levels of care for up to 69 residents. On the day of audit, the facility's occupancy was 65. There were 14 rest home level residents, 20 dementia level residents and 31 hospital level residents. One resident (dementia level) was under a young person with a disability YPD) contract. All remaining residents were under the ARCC contract. The Bupa organisation has documented vision and values statements that are shared with staff and are

and appropriate to the needs of consumers.		displayed. There is an overall Bupa strategic plan and risk management plan. The Booms has specific annual quality goals identified that link to the strategic plan and are reviewed each month in the staff/quality meetings. The Booms has an experienced care home manager who is a practising registered nurse (RN). She has been in the role for 13 years. The care home manager is supported by a clinical manager/RN who has been in the role for three years and has worked in aged care for eight years. The care home manager has maintained at least eight hours annually of professional development activities relating to managing an aged care facility.
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	In the absence of the care home manager, the administrative staff and the clinical manager/RN are in charge. In the absence of the clinical manager/RN, the unit coordinator/RN is in charge of clinical operations. For extended absences, a Bupa relieving care home manager is rostered.
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 programme is in place. Interviews with the care home manager and staff reflected their understanding of the quality and risk management systems. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in meeting minutes and on the staff noticeboard. Data collected (eg, falls, medication errors, wounds, skin tears, challenging behaviours) is collated and analysed with results communicated to staff. Corrective actions have been implemented where corrective actions indicate the need for improvements. An internal audit programme is in place. Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented. The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. Staff undergo health and safety training during their orientation. This training is repeated annually. The health and safety committee meets every month. Contractors are required to be inducted into the facility and

		sign a health and safety form when this has been completed. Bupa facilities belong to the ACC partnership programme and have achieved tertiary status. A range of falls prevention strategies are implemented including staff education, medication reviews for residents at risk of falling, and an investigation of each resident's fall on a case-by-case basis. Strategies implemented in the rest home wing have resulted in a significant reduction in falls for the 2018 year.
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	There is an accident and incident reporting policy. Adverse events are investigated by the clinical manager and/or registered nursing staff, evidenced in all ten accident/incident reports generated electronically on Riskman. Adverse events are analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations. Discussions with the care home manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. Examples were provided which included the reporting of four pressure injuries (2017), two residents who absconded (2017 and 2018) and one choking incident (2017). The DHB was notified of two infectious outbreaks in 2017.
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	There are human resources management policies in place, which include recruitment and staff selection processes. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates are held for all health professionals. Ten staff files were reviewed (three RNs, six caregivers and one cleaner). Reference checks are completed before employment is offered. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation package is specific to the job role and responsibilities. Annual practising certificates were current for all health professionals working at the facility. An in-service education programme is being implemented that is complimented by toolbox talks during handovers and a range of annual competency assessments. In-service education is being rostered as an annual study day, which has been reported by the care home manager as improving staff attendance. There is a minimum of one staff available twenty-four hours a day, seven days a week with a current first aid/CPR certificate. RN staff are working on completing their professional development recognition portfolios. Four out of nine RNs have submitted their portfolios. Four RNs are interRAI trained and three are scheduled to attend a course. Twelve caregivers are regularly rostered to work in the dementia unit. All twelve have completed the required

		dementia qualification.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A staff rationale and skill mix policy is in place. Sufficient staff are rostered to manage the care requirements of the residents. Extra staff are called on for increased residents' requirements with examples provided. Both the clinical manager and care home manager are RNs who work Monday – Friday. They are supported by a full-time unit coordinator/RN who works in all three areas Monday – Friday. Dementia wing (20 residents): AM: three caregivers are rostered (two 7.00 am – 3.00 pm and one 7.00 am – 10.00 am); PM: either one RN or one senior caregiver are rostered with support by three caregivers (one 3.00 pm – 9.00 pm, one 4.00 pm – 10.00 pm and one 5.00 pm – 7.00 pm); nights: one caregiver. An activities staff is rostered seven days a week for six hours per day. The five swing beds in the dementia/rest home unit have been opened only twice for dementia level of care for six weeks each time, over a period of the past eight years. Staffing requirements increase when this happens with the five beds treated as a separate wing. The swing beds have not been used for dementia level of care since the last audit. Hospital wing (31 residents): One RN is rostered on each shift. AM: five caregivers are rostered (three 7.00 am – 3.00 pm, two 7.00 am – 1.30 pm); PM five caregivers are rostered (two 3.00 pm – 9.00 pm, one 4.00 pm – 10.30 pm, one 5.00 pm – 10.00 pm, and one 5.00 pm – 7.00 pm), nights: one caregiver. Rest home wing (14 residents): AM: two caregivers are rostered (one 7.00 am – 3.00 pm and one 7.00 am – 1.00 pm); PM two caregivers are rostered (3.00 pm – 9.00 pm and 4.30 pm – 10.30 pm); nights: one caregiver. Activities staff are rostered specifically for the rest home and hospital, seven days a week for seven hours a day. There are separate cleaning and laundry staff. Interviews with staff, residents and family members indicated 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	FA	The residents' 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. Residents' files are protected from unauthorised access. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant caregiver or RN. Individual resident files demonstrate service integration. Medication charts are in a separate folder.

required.		
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	There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Eight admission agreements sighted were signed and dated. One very recent new admission has an agreement still with the family. This is to be posted back.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Policy 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.
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	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. All legal requirements had been met. There are no standing orders in use. There are no vaccines stored on-site. The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs and senior medication competent caregivers administer medications. Staff have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is checked daily. Eye drops are dated once opened. Staff sign for the administration of medications electronically. Eighteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.
Standard 1.3.13: Nutrition, Safe Food,	FA	The service has two cooks who each work four days on and four days off. There are two kitchenhands who each work four days on and four days off. There is also an afternoon assistant who works 1.30 pm – 7.00 pm. All have

And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on-site. Meals are taken to the dining rooms in bain maries and served directly from these. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by the Bupa dietitian. All residents and family members interviewed were satisfied with the meals. Some commented on the delicious home baking. There are snacks available at all times. The food control plan was approved on 14 August 2018.
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	The service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but are not limited to) falls risk, pressure injury risk, pain and depression.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. Resident falls are reported in 'Riskman' and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family are notified. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There are currently twenty wounds being managed. This includes six pressure injuries. One chronic wound and the stage three and stage four pressure injuries have had input from the GP and wound care nurse specialist. There are also photos to show wound progress. Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.
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	There is one activities coordinator who is a diversional therapist, and one activities assistant who each work four days on and four days off in the rest home and hospital. There are two activities assistants who each work four days on and four days off in the dementia unit. On the days of audit, residents were observed doing exercises, playing bingo and listening to music and entertainers. There is a weekly programme in large print on noticeboards and residents also have a copy in their rooms. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music and walks outside. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check

		if there is anything they need and to have a chat. There is an interdenominational church service held in the facility every second Sunday. Catholics have a volunteer come in to give communion. There are van outings at least three times weekly. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Fathers' Day, Anzac Day and Matariki are celebrated. The facility has two cats in the dementia unit, goldfish in the dementia unit and hospital and a pet therapy team visit twice yearly. Staff also bring in their pets. There is community input from volunteers, schools and dance groups. There is contact with a local kaumātua. Sometimes residents visit another rest home, go to art group or farm club. The YPD resident is in the dementia unit but comes out to daily exercises in the hospital and goes out in the van as often as possible. The YPD resident's partner brings in their dog to visit. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Resident meetings are held monthly. The recent move to seven-day activities cover was in response to a satisfaction survey. There also appeared to be a perception on the part of families that residents do not go out on outings often. To counter this perception the facility has put up an activities board with lots of recent photos of all the residents do (including outings). They also put in the monthly newsletter exactly what outings the residents have had.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The nine long-term care plans reviewed (apart from the new admission) had been evaluated by the registered nurses six-monthly or when changes to care occurs. Short- term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP/NP and resident/family if they wish to attend. There are three-monthly reviews by the GP for all residents. The family members interviewed confirmed that they are informed of any changes to the care plan.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		
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 are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharps containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.
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 30 June 2019. There is a maintenance person on-site for 30 hours a week. Contractors are used when required. The gardener is contracted. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. There is a mixture of carpet and vinyl flooring throughout the rest home and hospital. The dementia unit is all vinyl. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Ensuites, communal showers and toilets have nonslip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. The dementia unit garden is securely fenced. Caregivers interviewed stated they have adequate equipment to safely deliver cares for all levels of care

Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	The rest home has sixteen rooms with ensuites, the hospital has one and the dementia unit has two. There is one room in the hospital with a toilet and seven in the dementia unit. All rooms have hand basins. There are sufficient communal toilets and showers. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. There are signs on all shower/toilet doors.
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	All resident's rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
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	FA	There are large and small communal areas. Activities occur in the larger areas and the smaller areas are spaces where residents who prefer quieter activities or visitors may sit. One lounge opens out onto an attractive courtyard. There are spacious dining rooms in each area.

needs.		
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	All laundry is done on site. The laundry is run by two workers who cover seven days a week working four days on and four days off. The laundry is divided into a 'dirty' and 'clean' area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. There are three sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept locked when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbeque. A generator is readily available on standby through a local company. There is an approved fire evacuation scheme in place dated 15 April 2013. There are six-monthly fire drills. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty. All van drivers have first aid certificates as well. Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated light up on corridor lights that are visible from all areas in the facility. Security policies and procedures are documented and implemented by staff. The buildings are secure at night with access only available at reception through a secure keypad system. There is security lighting.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is	FA	All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed, stated that this is effective. There is an outdoor deck area where residents may smoke. All other areas are smoke free.

maintained at a safe and comfortable temperature.		
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 coordinator (ICC) is a RN. Responsibility for infection control is described in the job description. The ICC oversees infection control for the facility and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by Bupa. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks.
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	The ICC has only been in the role for five months, but has already attended a Bug Control study day and completed the ministry of health's online infection control course. The ICC is liaising with the local DHB to attend regional study days. There is access to infection control expertise within the DHB, Bupa, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics. The ICC also liaises and meets regularly with the care home and clinical managers.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant	FA	The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by a Bupa infection control specialist.

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICC is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have completed an infection control study day this year. The ICC has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
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	There is a policy describing surveillance methodology for monitoring of infections. The ICC collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed at staff and management meetings. Meeting minutes are available to staff. Trends are identified and analysed, and preventative measures put in place. The facility is looking at benchmarking with similar Bupa facilities. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were two hospital level residents using bedrails as a restraint and seven residents (two dementia level and five hospital level) with 'as needed' (PRN) hand holding restraint during cares. Four hospital level residents were using enablers under the restraint minimisation standard. A registered nurse is the restraint coordinator. She understands strategies around restraint minimisation. Staff

is actively minimised.		interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education including assessing staff competency on RMSP/enablers has been provided. Restraint is discussed as part of staff meetings and in separate restraint meetings.
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 (RN) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.
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. Assessments are undertaken by the RN in partnership with the GP, resident and their family/whānau. Oversight is provided by the restraint coordinator. Restraint assessments are based on information in the care plan, resident/family discussions and observations. Ongoing consultation with the resident and family/whānau are evident. Two residents using restraints (one using bedrails and one PRN hand holding during cares) were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint Use Services use restraint	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The use of restraint

safely		was linked to the resident's restraint care plan in both files reviewed. An internal restraint audit monitors staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring forms were sighted for both residents reviewed that indicated two hourly monitoring.
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). Evaluations take place three-monthly. Restraint use is discussed in a range of meetings (restraint meetings, staff meetings, RN meetings) confirmed in the meeting minutes.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The Bupa restraint minimisation programme is discussed and reviewed at a national level and includes identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and training programme. A teleconference with all restraint coordinators occurs annually. It was at the recent teleconference that PRN hand holding during resident cares was added to the list of approved restraints for Bupa facilities.

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.

No data to display

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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The facility has reduced the number of residents’ falls in the rest home and reduced the incidences of challenging behaviours in the dementia unit. Staff meetings include feedback on quality data where opportunities for improvement are identified.	There is also a number of on-going quality improvements identified through meeting minutes and as a result of analysis of quality data collected. The Booms is proactive in developing and implementing quality initiatives. For eg: The number of falls in the rest home wing have reduced from an average of 3.5 falls per month in 2017 to 1.3 falls per month in 2018 (year to date). Strategies implemented to reduce falls have included better management of infections in this population of residents, active physiotherapy referrals, resident education, staff education and ensuring that food and drinks are readily accessible.

End of the report.