# Bupa Care Services NZ Limited - Ascot Care House

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bupa Care Services NZ Limited

**Premises audited:** Ascot Care Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care

**Dates of audit:** Start date: 8 October 2019 End date: 9 October 2019

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 94

# 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 |
|  | 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

Ascot Care Home is part of the Bupa group. The service is certified to provide rest home, hospital (medical and geriatric), dementia and residential disability (physical) level of care for up to 104 residents. On the day of audit there were 94 residents.

This surveillance audit was conducted against a subset of the 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 and interviews with residents, family, management and staff.

The care home manager has been in the role since June 2019 and is an experienced care home manager. She is supported by a clinical manager who has also been in the role since June 2019.

Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

This audit has identified improvements required around; complaints documentation, internal audits, meetings, care plan documentation, and implementation of care.

## 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. |

Ascot Care Home has a culture of open disclosure. Families are regularly updated of residents’ condition including any acute changes or incidents. A complaints log is maintained, and complaints are responded to and followed up. Residents and family interviewed verified ongoing involvement with the community.

## 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 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.

There is a business plan with goals for the service that has been regularly reviewed. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care. 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. |

Registered nurses are responsible for care plan documentation. InterRAI assessments and care plans are completed within required timeframes. Planned activities are appropriate to the resident’s assessed needs and abilities. Residents and relatives advised satisfaction with the activities programme. The service uses an electronic medication management system. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritional snacks were available 24 hours a day in the dementia unit.

## 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 securely throughout the facility. The building holds a current warrant of fitness. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe, secure and well maintained. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Hot water temperatures are monitored.

## Restraint minimisation and safe practice

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

Restraint minimisation and safe practice policies and procedures are in place. At the time of the audit, the service had three residents using restraints (lap belts) and no residents with an enabler. Staff receive training in restraint minimisation and management of challenging behaviours.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The service engages in benchmarking with other Bupa facilities.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 14 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 4 | 1 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The care home manager maintains a record of all complaints, both verbal and written, by using an electronic complaint’s register.  Eighteen complaints made in 2018 and seventeen complaints received in 2019 year-to-date were documented and reviewed. Three reviewed in their entirety documented that an investigation had been undertaken, however two did not have evidence of follow-up, and not all had a documented acknowledgement, and one acknowledgement was not within timeframes.  Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Families interviewed stated that the current manager (who is new) was very approachable and proactive with any issues raised.  The Ministry requested follow up against aspects of a complaint that included communication with families/GP; service provision requirements; assessment – recognising deterioration/changes; planning- care plans reflect changing needs; service delivery/interventions - including referrals where required and evaluation – appropriate follow up when needs change. This audit has identified issues with care plan interventions (link 1.3.5.2); and implementation of care (link 1.3.6.1).  In response to the DHB pre-audit concerns;  Training has been provided around pressure injury interventions, skin care, urinary tract infections, critical thinking, and communication. Policies and procedures are in place around transfers to hospital, communication with GPs and other specialists. There were adequate activities in the dementia unit. Meal services and assisting residents with meals was observed to be well managed and call bell monitoring in place. The service had documented comprehensive action plans for the DHB issues identified and follow-up of the action plans had been documented and closed off. One refusal to re-admit a resident back to serviced was followed up and this was due to an outbreak. The resident was subsequently admitted once the outbreak had finished. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family is documented on the communication record in each resident’s file. Accident/incident forms on Riskman have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms reviewed across the service identified that family are kept informed. Relatives interviewed including; five hospital, two rest home and three with family in the dementia unit, stated that they have been kept informed when their family member’s health status changes.  An introduction to the dementia unit booklet provides information for family, friends and visitors to the facility. This booklet is included in the enquiry pack along with a new resident’s handbook providing practical information for residents and their families. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Ascot Care Home is part of the Bupa group. The service provides; hospital services - geriatric and medical, rest home care, residential disability services - physical and secure dementia services for up to 104 residents.  There are 40 rest home beds, 40 hospital level beds and 24 dementia care beds. On the day of audit there were 94 residents (35 rest home including one resident funded under long-term support chronic health conditions contract (LTS-CHC); 38 hospital level including one respite and one palliative care. The dementia unit had 21 residents). All other residents were under the age-related residential care (ARRC) contract and no resident funded under the younger persons contract.  A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. Ascot Care Home is part of the Southern Bupa region. The operations manager meets with and is in regular telephone contact with the manager. Monthly quality reports and operational reports are provided to head office.  Ascot Care Home has set a number of quality goals that link to the organisation’s quality and health and safety goals. Quality goals include (but are not limited to); (i) to reduce falls from last year by 10% and improve training and orientation for staff. Since commencing at the service, the care home manager and clinical manager have reviewed services and have developed a series of action plans to correct any issues identified (link 1.2.3.8). These action plans document review, updating and close off as needed. Team building and staff morale have been a focus since the clinical and care home managers arrival. Staff interviewed stated that they feel supported by the new management.  The care home manager has been in the role since June 2019. She has been a paramedic and has had previous experience in managing homes for older people. She is supported by a clinical manager who is also new to the role. The clinical manager is an experienced registered nurse with previous experience in elderly care as a clinical manager. The management team are supported by a team of nurses, an operations manager and the Bupa head office team.  The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service, including dementia level care. |
| 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. | PA Low | Bupa has a robust quality system documented. However, not all aspects of the quality system have been implemented at Ascot Care.  A series of meetings are scheduled to ensure communication and discussion of quality data, issues and service operations. These include registered nurse meetings, quality meetings, two weekly clinical review meetings, staff meetings and daily informal ‘catch up’ meetings for heads of departments. Additional meeting includes; health and safety, wound and skin management meetings lead by the DHB clinical nurse specialist for wounds and restraint meetings. Restraint meetings do not document discussion and review of restraint in use.  All incidents and accidents, infections and complaints are entered into the Riskman system and a monthly report generated. The service reports to the head office quality team for areas that are outside Bupa parameters and document adverse trends. Incidents and accidents are reported to the service meetings (link to 1.13.1). The quality meeting and the registered nurse meetings are the designated infection control group meetings; however, the infection control data is not documented as reported or discussed.  An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions have not always been established where indicated. Each month the service puts a series of easy to read posters up in the staff room advising staff of audit results, with an emoji designating if the audit outcome is good (or not).  There was an annual resident/relative satisfaction survey recently completed which has yet to be collated.  Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the health and safety committee. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. An employee health and safety programme (Smile) is in place, which is linked to the overarching Bupa National Health and Safety Plan. Falls prevention strategies are in place that includes the analysis of falls incidents 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 | The service collects incident and accident data on forms and enters them into Riskman. The system provides reports monthly, which are discussed at the monthly quality meetings. Incidents are benchmarked and analysed for trends, corrective action plans are documented for adverse trends and incidents that are outside Bupa set parameters. Ten incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The clinical manager collects incident forms, investigates and reviews and implements corrective actions as required. The next of kin had been notified for all required incidents/accidents and the relatives interviewed in the dementia unit stated they were notified of aggressive behaviour. The service has reported six category one events since the last audit to Bupa head office and to the relevant authorities, relating to; three outbreaks (one flu and two gastroenteritis) one resident against resident assault in the dementia unit (one resident has now moved to a different level of care), a power outage and a van crash (no residents were injured). |
| 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 policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (one enrolled nurse, one registered nurse and three caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. Current practising certificates were sighted for the registered nurses. All required staff have been employed and appropriate employment practices followed.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice and a level two qualification. There are 12 caregivers who work in the dementia unit and five have completed the required dementia standards. Four caregivers are in the process of completing their qualification. The three caregivers that have not completed have commenced work within the last six months.  Staff interviewed believed new staff are adequately orientated to the service on employment.  There is a comprehensive annual education planner in place that covers compulsory education requirements. Additional education has been provided via toolbox talks. Toolbox talks have included; recognition and treatment of urinary tract infections, pain assessments, and prevention of urinary tract infections. Other training has included; critical thinking for RNs provided by the Bupa quality team, family follow-up and communication, person first (dementia training) by the Bupa dementia specialist nurse. There are 13 registered nurses and 7 of interRAI trained.  There are a number of competencies completed by registered nurses and caregiving staff.  Training sessions have been repeated to allow more staff to attended and the planner and individual attendance records are updated after each session. |
| 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. Ascot Care Home has a four-weekly roster in place which ensures there are adequate staffing levels to meet the acuity and safety needs of the residents. Interviews with residents and family members identified that staffing is adequate to meet the needs of residents. The care home manager and clinical manager work fulltime and are available during weekdays. The care home manager and the clinical manager share the on-call duties. Adequate RN cover is provided 24 hours a day, seven days a week.  In the hospital (38 hospital residents at the time of audit):  AM; there is one-unit coordinator and one RN or EN. There are two RNs for the PM shift and one RN at night.  There are four long shifts and two short shifts caregivers on duty on the morning. There are two long and two short shifts caregivers for the PM shift and two caregivers on the night shift.  In the rest home (35 rest home residents at the time of audit):  AM there is one-unit coordinator and one RN/EN on the morning shift and one RN/EN on the afternoon shift.  There are two long shift and two short shift caregivers on duty on the morning and one long shift and two short shifts caregivers on the afternoon shifts. There are two caregivers on the night shift.  In the dementia care unit (21 dementia residents):  There is one RN/EN on the morning and afternoon shifts. There are two caregivers on duty on the morning and afternoon shifts, and one caregiver on the night shift.  Residents, family and staff felt the staff was overall safe and appropriate to support resident care. Call bell response times are monitored, and an action plan has been documented with evidence of repeat audits and follow up. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The service uses individualised two weekly robotic packs for regular and blister packs for ‘as required’ (PRN) medications. Medication reconciliation is completed by an RN and any errors are fed back to pharmacy. All medications were securely and appropriately stored on the day of audit.  All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration had been provided. RNs have completed syringe driver training.  Fourteen medication charts were reviewed (six rest home, four hospital and four dementia). The service uses an electronic medication management system. All charts had evidence of three-monthly reviews by the GP, and all medications were prescribed appropriately.  Staff were observed to be safely administering medications. Registered nurses and caregivers interviewed could describe their role regarding medicine administration. Standing orders are not used. Three residents were self-medicating (two rest home and one hospital), a competency was in place and reviewed by the GP on a three-monthly basis.  The medication fridge temperatures are recorded weekly and these were within acceptable ranges.  Oxygen was prescribed for the three residents requiring continuous oxygen via a concentrator. This was signed off as administered on the electronic system. Residents using oxygen had monitoring forms in place (link 1.3.6.1). |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals are prepared and cooked on-site. A Bupa-wide summer and winter menu are of a six-weekly cycle. There is a monthly on-line forum for all Bupa facilities cooks. There are three kitchen staff on duty each day including a qualified cook (8 am - 4.30 pm) and morning and afternoon kitchenhands. The national menus have been audited and approved by an external dietitian. Meals are served from the bain marie in the kitchen to residents in the rest home dining room and transported in hot boxes to bain maries in the hospital and dementia unit kitchenettes and served by care staff. The cook serves the meals in the hospital wing at lunchtime to monitor ‘who is eating and who is not’. The cook attends the twice weekly clinical meetings and keeps abreast of changes in resident weight status. All kitchen staff (two cooks and four kitchenhands) have NZQA167 qualifications. Both cooks have NZQA168 qualifications.  Resident likes and dislikes are known, and alternative choices offered. The residents have a nutritional profile developed on admission and the kitchen staff receive a copy, which identifies the residents’ dietary requirements and likes and dislikes. Special diets include gluten free, no pork and moulied. Lip plates and specialised utensils are provided to promote and maintain independence with meals. Staff were observed in the hospital wing assisting residents with their meals at the midday meal. A food service plan has been approved and expires September 2020. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Bupa Ascot uses the Bupa assessment booklets and person-centred templates for all residents. The assessment booklet includes; falls, Braden pressure area, skin, mini nutritional, continence, pain, activities and culture. Nutritional requirements are completed on admission. Additional risk assessment tools include behaviour and wound assessments as applicable. The outcomes of risk assessments reviewed were reflected in the care plans.  InterRAI assessments had been completed within timeframes and areas triggered were addressed in care plans sampled. The respite and exceptional circumstances residents both had appropriate assessments completed. Behaviour assessments were completed as required. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate. All resident files reviewed included a care plan, however not all resident assessed needs were addressed in the care plans. Goals and outcomes were identified and agreed and how care is to be delivered is explained.  The skin integrity section of the care plan includes interventions including; application of moisturiser, checking skin and reporting of changes, checking pressure equipment each shift, two hourly turning (which was maintained, but not documented as completed link 1.3.6.1), resting after lunch on the bed, protection and elevation of heels, nutrition and continence needs were considered. Progress note entries by the caregivers identify the level of assistance required with personal cares, food and fluid intake, and any concerns. There was evidence of RN follow-up and a short-term care plan in place if further interventions were required.  Two residents who required oxygen therapy had this included in the care plan, however monitoring was not constantly documented as monitored as per the care plan instructions (link 1.3.6.1).  The resident on the palliative care contract had input from the Hospice, but as the resident’s condition had improved since being admitted to Bupa Ascot, the resident, relative, staff and members of the community team were preparing for the resident to go home. There had been initial conversations around what the resident would wish for the end of their life, but no planning had occurred around this as the resident was becoming more independent and well. The resident and relative were interviewed and stated they can call on the Hospice for advice as they need this. The Hospice CNS visits regularly. Staff training around communication and family follow-up was provided June 2019 and staff training provided by the polytechnic has been booked for October around communication and dying.  Care plans demonstrated service integration. Assessments and care plans are comprehensive and include input from allied health including geriatrician, mental health for older persons nurse practitioner, hospice, dietitians, wound nurse specialist, physiotherapy and podiatry. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident's condition alters, the RN initiates a review and if required a GP visit. When a resident’s change in health status was identified, communication between the GP and staff was sighted in the resident’s files. Residents and relatives interviewed stated their needs were being appropriately met.  On the day of the audit, there were three facility acquired pressure injuries two hospital (one stage 2, one stage 1) and one resident in the rest home had a stage 2 pressure injury. There were two non-facility acquired pressure injuries. All pressure injuries had wound assessments, plans and evaluations. A review of documentation evidenced that all pressure injuries were healing. The wound care specialist has been involved where required.  There were six wounds in the rest home community (two chronic wounds, two skin tears, one dressing due to leakage of a lower limb, and one blister) and three in the dementia community (two surgical wounds, one chronic ulcer), and six in the hospital community (two chronic ulcers, four superficial skin tears). All wounds had a wound assessment, plan and evaluation. The GP was aware of the chronic wounds and pressure injuries as documented in the GP notes. The treatment rooms in each area had adequate supplies of dressings. Staff receive wound education sessions. Short-term care plans were in place for residents with current wounds. Chronic wounds were identified in the long-term care plans and interventions identified.  The registered nurses interviewed were knowledgeable around the prevention and treatment of pressure injuries. Pressure injury prevention equipment was in place for all residents with a current pressure injury, however staff were not always completing turning charts as instructed in care plans. If residents were independent with turning, this was documented in the short-term care plans.  Continence products are available and resident files included urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.  Monitoring forms in place include (but not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels, wound charts and behaviour charts. |
| 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 activities team at Bupa Ascot is comprised of one activities coordinator and one activities assistant (currently one vacancy) who offer activities for residents in all areas of the home.  The activities coordinator interviewed has been employed since October 2018 and works 40 hours a week, the activities assistant (qualified diversional therapist) has been employed more recently and works 32 hours a week. Both work between the dementia and rest home/hospital areas.  The activity team have access to the Bupa diversional therapy (DT) team at head office. Each resident has an individual activities assessment, plan and map of life, which is reviewed at least six monthly for long-term residents. There are large open plan central lounge/dining areas which are used for activities for rest home and hospital. There are separate rest home/hospital and dementia programmes including some integrated activities, such as musical entertainment, as observed on the day of audit.  Activities are provided in the dementia unit between 10.30 am - 3.30 pm then 6.30 pm - 8.30 pm two nights a week until the vacancy is covered. Then this will be covered over the seven days. Activities include newspaper reading and exercises daily, walks, group games, musical activities and movies. Relatives who were interviewed in the dementia unit felt there were enough activities on offer.  Activities in the rest home/hospital areas are from 10.30 am – 3.30 pm. Variations to the group programme are made known to the residents. Residents may choose to participate in any group programme. Individual programmes are delivered to residents in their rooms when they are unable to or choose not to participate in the group programme. There are regular visiting entertainers, musical therapy, and community groups. A weekly rotation of local churches come to provide church services. Residents can go on outings using the service’s van, and there is a local community van suitable for residents in wheelchairs which is utilised. Residents visit other Bupa facilities in the community.  Some rest home residents choose to use alternative transport arrangements to attend community interests. Activities are discussed at the monthly resident meeting and residents provide suggestions for future activities as sighted in the minutes. Residents and relatives interviewed in the rest home and hospital areas felt activities have improved recently. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All long-term resident care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations described the residents progress against the residents (as appropriate) identified goals. Short-term care plans in place for acute needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involved the RN, GP, resident and family and other members of the allied health team as required. Relatives are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The relatives interviewed confirmed they were invited to attend the multidisciplinary care plan reviews and GP visits. |
| 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. The facility full-time maintenance manager has recently left, and this role is currently being carried out by the Household Supervisor who has been there for 5½ years. There are proactive and reactive maintenance management plans in place. The grounds and gardens are well maintained and accessible.  Contracted providers test equipment with electrical testing of non-hard-wired equipment annually. Medical equipment requiring servicing and calibration was last conducted in August 2019.  There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors to the facility. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. There are safe and secure garden areas in the dementia unit with seating and shade provided. |
| 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 | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and local laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control officer. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. At the time of the audit, the service had three residents using restraints (lap belts) and no residents with an enabler. However, care plan interventions were not well documented (link 1.3.5.2) and monitoring not consistently documented (link 1.3.6.1). Staff training around restraint minimisation was provided March 2019 and management of challenging behaviours was last completed November 2018. |

# 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.

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| **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 | There is a robust policy and procedure in place to manage complaints. All complaints are logged onto Riskman. Complaints are managed by the manager and more serious or complaints causing concern are managed though Bupa head office. A customer liaison person is also available to assist with complainant communication during and after the complaint process. Not all complaints have been managed in line with the code. | Of the three complaints followed up in their entirety, the following was evidenced;  (i). Two of three did not have an acknowledgement of the complaint.  (ii) One complaint that included an acknowledgment, was not within timeframes.  (ii). Two of three complaints did not evidence follow-up such as an action plan or review of issues raised through meeting minutes. | (i). Ensure that complaints are acknowledged as per Bupa policy.  (ii). Ensure that complaint documentation is within timeframes set by Bupa policy.  (iii). Ensure that issues raised through complaints have a documented follow-up process to enable service improvement.  90 days |
| Criterion 1.2.3.5  Key components of service delivery shall be explicitly linked to the quality management system. | PA Low | A wide variety of meetings are documented at the service. Two weekly clinical review meetings document that clinical care has taken a high priority and the meeting minutes document robust discussion and follow-up of issues raised. Infection control meetings and restraint meetings have not documented that issues/clinical outcomes for these two clinical streams have been discussed. | The designated restraint meeting does not document the discussion and evaluation of restraint use. Only numbers and names of residents who are restrained are documented. The correct use of restraint was noted to be an issue at this audit and minutes of meetings did not document this had been noted and reviewed. The RN and quality meetings are the designated IC meeting, five of seven months of the quality meetings and all of the RN meetings did not document review and discussion of infection control or infection log results. | Ensure that the restraint meeting minutes evidence review and evaluation of restraint use.  Ensure that infection control quality data and clinical outcomes are documented as reviewed, evaluated and discussed  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Since joining the service, the clinical manager and care home manager have reviewed the service and developed action plans. These action plans have been documented as evaluated, closed off or updated as needed. The implemented Bupa internal audit schedule did not always document an action plan where shortfalls were identified. | Internal audits did not document an action plan where shortfalls had been noted, including; the incident internal audit - April, care planning audit - May, medication audit, multi-disciplinary review audit and weight audit – August. | Ensure that action plans are documented where a shortfall is identified following internal audits.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Monitoring charts were in place for a resident in the dementia unit, which documented whether triggers could be identified, the behaviour displayed by the resident and effective de-escalation techniques tried. The staff in the unit could describe all of the information in the monitoring form, however, this was not documented in the care plan.  Three resident files for residents with restraint had this restraint included in the care plan, however the care plan was not specific about when the restraint should be used and where the resident prefers to sleep at night. All three files documented that the residents slept in their chairs and were restrained for some nights due to restlessness. | i) No individual triggers or resident specific de-escalation techniques were identified in two of two dementia files.  ii) Three of three residents were currently on a T-belt restraint. The care plan did not document what to do if the resident is restless during the night. The monitoring chart indicated the residents were sitting in a lazy boy chair and restrained overnight. | Ensure all care interventions are documented in the care plan.  60 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 Low | There was a suite of monitoring forms for staff to utilise to monitor the condition of residents, however, these were not consistently completed. | (i) There was no turning chart in place as stipulated in the LTCP for a hospital resident with a current pressure injury.  ii) A hospital level resident on continuous oxygen had no oxygen monitoring chart in place as per policy.  iii) One fluid balance chart was not consistently recorded for one hospital level resident.  iv) Three of three files of residents that utilise restraints do not document monitoring during the day. | Ensure all monitoring charts are fully completed as instructed in the care plans.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.