Bupa Care Services NZ Limited - Longwood Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Longwood Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 August 2020 End date: 25 August 2020

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: 48

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Longwood Rest Home is part of the Bupa group. The service is certified to provide rest home and hospital level care for up to 52 residents. On the day of audit there were 48 residents.

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

The service is managed by an experienced care home manager who has been in her role for six years and is a registered nurse. The care home manager is supported by a clinical manager, a Bupa regional manager, registered nurses and long-standing experienced staff.

The GP, residents and relatives interviewed, all spoke positively about the home, staff and the care provided.

There are well-developed systems, processes, policies, and procedures that are structured to provide appropriate quality care for people who live in the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to Longwood. Quality initiatives are implemented which provide evidence of improved services for residents.

There were no improvements identified during this audit.

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. 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. Complaints and concerns have been managed and an electronic 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 a clinical manager, registered nurses, caregivers and support staff. The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident meetings are held, and there are regular resident/relative newsletters. Satisfaction is monitored via annual satisfaction surveys.

Health and safety policies, systems and processes are implemented to manage risk.

Appropriate employment processes are adhered to. An education and training programme is established. The roster 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.

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. There is a comprehensive admission package available prior to or on entry to the service. The residents and family/whānau interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. A sample of residents' files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. Resident files included medical notes by the general practitioner and allied health professionals.

Planned activities are appropriate to the resident groups. The programme includes outings, entertainment, community visitors, and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each consumer group. Residents and family members interviewed confirmed satisfaction with the activities programme.

Medication policies reflect legislative requirements and guidelines. Staff responsible for medication management have current medication competencies. Medication records had been reviewed at least three monthly by the general practitioner.

All meals and baking are done on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required. The menu is reviewed annually by an external dietitian. Residents and family/whānau commented positively on the meals provided.

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.

The building holds a current warrant of fitness. Resident rooms are single, spacious and personalised. Communal areas within each area are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are well monitored through the internal auditing system. Chemicals are stored securely throughout the facility. Appropriate training, information and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The facility temperature is comfortable and constant.

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 and implemented. There were two residents using restraints and seven residents using enablers during the audit. A registered nurse is the designated restraint coordinator. Staff are offered training in restraint minimisation and challenging behaviour management, which begins during their orientation to the service.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training in infection control. The service continues to maintain current Covid 19 restrictions as per Bupa policy, and continue to maintain a log of visitors for contact tracing. Hand gel is freely available, and masks were issued to visitors on arrival to the facility.

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	0	101	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, the clinical manager, one registered nurse, one enrolled nurse, one diversional therapist, and five caregivers, confirmed their familiarity with the Code. Aspects of the Code are discussed at meetings as required. A training session on the code of rights was last held in May 2019.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There was informed consent policies, procedures and advanced directives in place. In the seven files (three rest home, four hospital including, one ACC - hospital on respite, one young person disability agreement), two files were of recently admitted residents; one of whom has an activated enduring power of attorney and as yet do not have their signed admission agreements and general consent forms. One new resident had signed the general consent form, but their enduring power of attorney was not yet activated. In the files sampled there was evidence of family/EPOA discussion with the GP for medically indicated not for resuscitation status where residents were not deemed to be competent. Discussions with residents and family/whānau where appropriate, and client files demonstrated they are involved in the decision-making process and in the planning of the resident's care. Staff confirmed they are familiar with the requirements to obtain informed consent when entering rooms

		and providing personal cares.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy support services is included in the resident information pack that is provided to EPOA and relatives on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with relatives confirmed their understanding of the availability of advocacy support services. Interviews with management and staff confirmed that practice is consistent with policy, and staff were aware of how to support relatives to access an advocate when needed. The resident files include information on residents' family/whānau/EPOA and support networks. Staff receive training on advocacy.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time (as Covid 19 restrictions allow). The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held bi-monthly. Monthly newsletters are provided to residents and relatives. Residents maintain their links with community groups such as the RSA, attending the local pub with friends, and van outings have increased recently to two per week. Residents are often invited to community events an luncheons.
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 reception. Information about complaints is provided on admission. Interviews with residents and relatives demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is an electronic complaint register. One complaint has been received since the last audit in March 2019 around care of a resident. The matter was resolved on the same day. Corrective actions following complaints have included discussions with the nurses, and staff on the day and at handovers. The relative was informed of the investigation findings and corrective actions in place. Complaints are discussed in quality meetings. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	There are posters displaying the Code. The service is able to provide information in different languages and/or in large print if requested. On entry to the service the RN responsible for admitting the resident

Consumers are informed of their rights.		discusses the Code with the resident and the family/whānau. Information is given in the information pack to the resident, next of kin or enduring power of attorney (EPOA) to read and discuss. Interviews with six residents (five from the rest home and one at hospital level) and five relatives (two hospital and three rest home) confirmed that the services being provided are in line with the Code.
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 implemented the Bupa policies which align with requirements of the Privacy Act and Health Information Privacy Code. The care home manager is the privacy officer. During the audit, staff were observed gaining permission prior to entering residents' rooms. All caregivers interviewed demonstrated an understanding of privacy and could describe how choice is incorporated into residents' cares. Residents and family members interviewed confirmed that staff promote the residents' independence wherever possible and that residents' choices are encouraged. Training on privacy and code of conduct was held in July 2020. There is an abuse and neglect policy that is implemented, and staff have undertaken training on abuse and neglect in September 2019.
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. Linkages to local Iwi and community members (Oraka Aparima Runaka) are available for residents for spiritual and Māori Health needs. One resident is involved with Nga Ketu for holistic care, counselling, and Miri. The local kaumātua are available to bless the home as required. One resident identified as Māori on the day of the audit. Preferences and affiliations were documented in the resident file and care plan. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic, last occurring in June 2019. The caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural,	FA	The service has established cultural policies aimed at helping to meet the cultural needs of its residents; all residents at the time of audit were able to communicate in English. The 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, is used to develop a care plan which the resident (if appropriate) and/or their family/whānau are asked to consult on. Cultural preferences are also identified in the resident's map of

spiritual values, and beliefs.		life and 'my day/my way' documentation. Discussions with staff confirmed that they are aware of the need to respond to the cultural needs of the residents. Links are identified with the local community.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with all 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. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures are being reviewed and updated at organisational level and are available to staff once they have been approved. There are clear ethical and professional standards and boundaries within job descriptions. Registered nursing staff are available 24 hours a day, 7 days a week. The service receives support from the Southern District Health Board (SDHB) which includes visits from specialists on referral. Physiotherapy services are provided three hours per week, and a physiotherapy assistant is on site six hours a week. The service is working alongside the physiotherapy service to improve residents' movement, pain and muscle strength by promoting passive exercises as guided by the physiotherapist. A copy of the exercises for residents are available on the residents' room for staff to complete as part of cares. Education and training for staff includes in-service training and competency assessments. Podiatry services and hairdressing services are provided. The service has links with the local community and encourages residents to remain as independent as possible. Longwood is benchmarked against the rest home and hospital data. If the results are above the benchmark, a corrective action plan is developed by the service and discussed at meetings with staff. Longwood have been working on reducing pressure injuries by 50% from 2019. Through purchasing more pressure relieving equipment, education and increased quality of assessments, the numbers of facility acquired pressure injuries have remained low, with one facility acquired pressure injury for 2020 to date. Caregivers interviewed could fluently describe the measures taken and reporting of skin condition to the nurses. The management of Longwood have joined the multidisciplinary (MDT) meetings held by the SDHB to

		provide a coordinated approach to the care and wellbeing of residents. Members of the team include Hospice, nurse practitioner for services of older people, nurse practitioner for mental health and other members of the team as required.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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 family communication is held in each resident's file. Regular resident meetings provide a venue where issues can be addressed. The diversional therapist visits each resident and discusses the agenda prior to the meeting to ensure each resident has an opportunity to provide feedback, as they may not feel comfortable speaking in front of a group of people. Fifteen incident/accidents forms randomly selected for review indicated that family were informed. Families interviewed confirmed they are notified of any changes in their family member's health status. Interpreter services are available if needed. The information pack is available in large print and is read to residents who require assistance. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Longwood Rest Home is certified to provide hospital (medical and geriatric) and rest home level care for up to 52 residents. On the day of audit there were 48 residents in total, 23 rest home residents including one resident on a ACC funded contract waiting to be reassessed as hospital level care, and 25 hospital residents including one resident on a younger person with a disability (YPD) contract, one long term ACC contract, and one resident on a short stay ACC contract. All other residents are on the aged residential care (ARC) contract. There are 18 dual-purpose beds between the rest home and hospital. The service is managed by an experienced registered nurse (RN) who has been the care home manager at Longwood since 2014 and is supported by a clinical manager who has been in this position for the same length of time. Care home managers and clinical managers attend annual organisational forums and regional forums six-monthly. The regional operations manager visits monthly and more often if required. Bupa's overall vision and values are displayed in a visible location. All staff are made aware of the vision and values during their induction to the service. There is an overarching Bupa business plan and

		risk management plan. Longwood goals for 2020 include improving the activities programme, maintaining high infection control standards, and improving residents exercise, pain and muscle strength. Goals are reviewed monthly and signed off when achieved. Progress towards these goals is minuted in the various meetings held at the service. 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 enrolling in the pressure injury forum, conferences and ARC meetings.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The clinical manager who is employed full time steps in when the care home manager is absent.
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	Bupa Longwood continues to implement its comprehensive quality and risk programme. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff interviewed confirmed they are made aware of any new/reviewed policies. A range of meetings are held, these include monthly staff meetings, monthly quality meetings that include health and safety and infection control, bi-monthly resident meetings, and monthly RN meetings. Meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. All meeting minutes are posted in the staffroom for staff to read. Extra meetings with kitchen, laundry and cleaning staff were held during the Covid 19 period as required. Staff interviewed stated they are well-informed and receive quality and risk management information such as a monthly adverse event summary. The service collates accident/incident and infection control data. Monthly comparisons include trend analysis and graphs. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified

		and are signed off when completed. The annual relative satisfaction survey 2019 has been followed up with corrective actions around refurbishing bedrooms, reviewing the dining experience and a review of the activities programme. The resident satisfaction survey showed a 94% satisfaction rate, with slight improvements from 2018 around staff, rooms, food, and the quality of care. The 2020 survey has yet to be completed. There is an implemented health and safety and risk management system in place including policies to guide practice. The care home manager with the health and safety committee are responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings. All members of the health and safety committee have completed external training. Falls management strategies include assessments after falls and individualised strategies.
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 an electronic register (RiskMan). The system provides reports monthly, and the clinical manager reviews all incidents each month and writes a report. Corrective action plans (CAP) are documented for adverse trends. An example was high falls for January; there is a report and corrective action plan documented. The report and CAP were documented and signed off as followed up. Graphs and pie charts were available for staff in the staffroom. Each unit maintains a folder of the monthly reports for staff to read. All incidents and accidents are trended and benchmarked. Fourteen incident and accident forms were reviewed (five rest home and nine hospital). 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 next of kin had been notified for all required incidents/accidents. All incident forms document comprehensive review and follow up, opportunities to minimise future risks were documented where possible. The caregivers interviewed could discuss the incident reporting process. Staff-related incident forms are discussed at the health and safety meeting. The care home manager interviewed could describe situations that would require reporting to relevant authorities. Two section 31 notifications have been made since the previous audit (sighted) for a stage 3 pressure injury and sprinkler failure.
Standard 1.2.7: Human Resource	FA	Human resource management policies in place which includes the recruitment and staff selection

Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. A register of current practising certificates is maintained. Eight staff files reviewed (three caregivers, two RNs, one clinical manager one housekeeper and one DT) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements, job descriptions and up-to-date staff appraisals. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. There is an attendance register for each training session and an individual staff member record of training. Opportunistic education (toolbox talks) are provided during handovers. The competency programme has different requirements according to work type (eg, caregivers, RN, and cleaner). Core competencies are completed annually, and a record of completion is maintained – competency register sighted. The completion of the orientation workbook is the equivalent of level 2 NZQA qualification. Currently there are 3 caregivers with level 4 NZQA, 17 with level 3 and 12 with level 2. Registered nurses are supported to maintain their professional competency. Eight registered nurses and one enrolled nurse are employed. One RN and the clinical manager have completed their interRAI training. There are implemented training sessions and competencies for registered nurses including (but not limited to) medication competencies, Bupa RN training days and training through the Southern District Health Board (SDHB).
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. The care home manager and the clinical manager are RNs who are employed on a full-time basis (Monday – Friday). They are supported by a registered nurse seven days a week across all shifts and an enrolled nurse two days a week. The rest home and hospital wings had full capacity and there were two empty rooms in the dual-purpose wing. The Hillcrest hospital level care wing had 20 residents including two rest home and one hospital level short stay resident. Morning shift: There is one RN, and five caregivers: 2x 7 am to 3 pm, 2x 7 am to 1.30 pm (this is a flexi shift and can be extended if required) and a breakfast shift from 7 am to 10 am. The afternoon shift is covered by an RN and four caregivers: 2x 3 pm to 9 pm (flexi to 10 pm), 2x 3.30 pm to 11 pm and 1x 5 pm to 8 pm. In the Meadowlea rest home wing had 14 residents including three hospital level care: AM: There is one caregiver from 7 am to 3.15 pm. The afternoon shift is covered by one caregiver who

		works 3 pm to 11 pm. In the Oceanview/ Seaview wing (dual-purpose) had 15 residents, 12 rest home, and three hospital. AM; There is two caregivers: 1x 7 am to 3.15 pm and 1x 7 am to 1.30 pm (flexi till 3 pm if needed). PM: There is two caregivers: 1x 3 pm to 11.15 pm and one 3.30 pm to 9.30 pm. On the night shift there is one RN (10.45 pm to 7.15 am) and two caregivers (11 pm to 7.15 am) for the service. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The 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.
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 appropriate policies and procedures for entry to the service. This includes requirements and procedures to be followed when a resident is admitted to the service. The admission agreement reviewed aligned with the Aged Residential Care agreement. Admission agreements were signed in the resident records sampled. All residents had the appropriate needs assessments prior to admission to the service. The service has specific information available for residents/families/EPOA at entry and it included associated information such as the Code, advocacy and complaints procedure.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a policy in place with guidelines for death, discharge, transfer, documentation and follow-up. All relevant information is documented on the Bupa transfer form and accompanied with a copy of the resident admission form, most recent GP consultation notes and medication information. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification of appointments and transfers. Relatives interviewed confirmed that they are notified and kept informed of the resident's condition.

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	Registered nurses and medication competent caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. There are no standing orders in place. There was one resident self-administering medications at the time of audit. The self-medicating competency and monitoring was in place three monthly. There are two medication rooms with key access. The medication fridge and medication rooms have temperatures recorded daily and these were within acceptable ranges. There is an agreement with the pharmacy. The facility uses a robotics pack medication management system for the packaging of all tablets. Eyedrops and other liquid medications were dated on opening. Controlled drugs are stored securely. The register evidenced weekly checking and six-monthly quantity stock checks by the pharmacy. There was no expired medication on site. The facility utilises an electronic medication management system for all long-term residents. Fourteen medication charts were reviewed (seven hospital and seven rest home) that had photo identification documented on the chart. All residents' files within the electronic medication charting system had allergies documented. All medication charts evidenced three monthly reviews by the GP. Prescribed medication was signed after being administered as witnessed on the day of the audit. All 'as required' medication prescribed had indications for use documented by the GP. Effectiveness of 'as required' medication administered was documented.
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. The cook oversees the food services and is supported by kitchen staff on duty each day. The main meal is at lunch time. The service utilises a four weekly summer and winter menu that has been reviewed by the Bupa dietitian. The kitchen receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Rest-home resident meals are served in the dining room adjacent to the kitchen, hospital residents' meals are delivered in a bain marie to the kitchenette where they are served, several residents choose to eat in their rooms. Serving temperatures from a bain marie are monitored. The cook and one kitchen assistant were interviewed and confirmed they are notified of any residents with weight loss. Protein drinks and fluids were available in the kitchenette fridges. Lip plates and specialised utensils are provided to promote and maintain independence with meals. Fridge, freezer and end-cooked meat temperatures are taken and recorded daily. Perishable foods sighted in the kitchen pantry were dated and stored in sealed containers. Staff have received training in chemical safety. One staff member is undertaking a cookery apprenticeship with the others completing four unit standards. Chemicals

		sighted were stored safely. A signed cleaning schedule is maintained. There is a current food control plan in place which expires on 23 April 2021. Temperatures are recorded on all chilled and frozen food deliveries. Fridges (including facility fridges) and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Cleaning schedules are maintained. Staff were observed assisting residents with their meals. Resident meetings and surveys, along with direct input from residents, provides resident feedback on the meals and food services generally. Residents interviewed on the day of the audit were all complimentary of the meals. Family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
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	Declining entry records are kept. If a potential resident is declined entry it is usually because the care, they require is not able to be provided or there are no beds available. When this occurs the care manager or clinical manager informs the referral agency, and this is communicated to their family/whānau.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The service uses the Bupa assessment booklets and person-centred templates for all residents on admission. The assessment booklet includes falls, Braden pressure area, skin, mini nutritional, continence, pain activities and culture. Nutritional and dietary requirements are also completed on admission. Additional risk assessment tools include behaviour and wound assessments as applicable. The interRAI process is being implemented and ongoing interRAI assessments have been completed six monthly, or earlier due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others as verified in the staff and family/whānau interviews. InterRAI assessments, assessment notes and summary were in place for four of the seven files. Two of the seven files were of newly admitted residents yet to have their 21-day interRAI with one file a hospital respite resident. The outcomes of the assessments are reflected in the care plan of long-term residents and the short-term and summary care plans.
Standard 1.3.5: Planning Consumers' service delivery plans	FA	The initial care plan is developed from the initial admission assessment process and the needs identified by the registered nurse. Comprehensive long-term care plans are individually developed and were reflective of the outcomes of the interRAI and risk assessment tools completed. Long-term care

are consumer focused, integrated, and promote continuity of service delivery.		plans are completed in consultation with the resident and/or family/whānau. Residents and family members interviewed stated they were involved in the care planning process. The long-term care plans reviewed were up to date. Nursing diagnosis, goals and outcomes were identified. Care plan interventions were individualised for each resident. Interventions in the long-term care plans reviewed recorded sufficient detail to guide care staff. Activities care plans were completed for all seven resident files. Activity plans are reviewed six-monthly with the long-term care plans. The four long-term residents have been seen by the GP at least three monthly or more frequently if required. The newly admitted residents had seen the GP within five days of admission. All files recorded progress in the medical records and noted reviews on the residents' medicine management charts. Short-term care plans were being used for acute changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The seven care plans reviewed included interventions that reflected the resident's current needs. When a resident's condition changes the registered nurse initiates a GP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products were identified. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers and RNs interviewed stated there is adequate continence and wound care supplies. Individual wound assessment, wound management plan and evaluation forms were in place for all wounds. Rest home residents had three wounds: a suture removal, wounds on the left shin and the right second toe. Hospital residents had eight wounds: this included the resolving one stage 2 pressure injury that was not facility acquired; an ingrown toenail; three areas on the lower legs; one area where sutures had been removed; one toe and sacrum wound (that is not a pressure area). The wound care nurse is available as necessary. Monitoring charts reviewed included monthly and weekly weight charts, monthly vital signs and neurological observations post-unwitnessed falls.
Standard 1.3.7: Planned Activities Where specified as part of the	FA	Bupa Longwood employs one diversional therapist and two activities assistants. The second activities assistant has recently been made a permanent appointment to assist in providing six days per week.

service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.		The diversional therapist is involved in the admission process, completing the initial activities assessment and has input with the cultural assessment, 'map of life' and 'my day my way' adding additional information as appropriate. All activities plans were completed within timeframes, a monthly record of attendance to activities is maintained and evaluations are completed six-monthly. The monthly and weekly programmes are displayed on noticeboards throughout the facility. There are a general range of activities for all residents to join in and activities for more able residents. The activities coordinator stated that the programme varies according to resident requests. The activities team provides individual and group activities for all residents. Entertainers visit and there is a weekly church service held on a Sunday with input from a variety of denominations. On the days of the audit residents were observed participating in quizzes, and walking activities. Residents and families interviewed were happy with the activities programme and content. The service continues to improve on the continuous improvement awarded at the last certification audit around activities. Many hospital level residents are no longer able or willing to attend group activities due to deterioration in health and are needing more individual activities. The activities team identified the potential for improvements in the activity programme. The focus was to promote and extend the activities programme focussing on developing a robust programme for those residents that are unable or unwilling to participate in group activity, and to focus on the existing community programme and increasing community involvement with the residents. A number of actions were taken to improve the activities programme, this included: increased staffing - another activities assistant has been employed for 12 hours weekly, residents needing one-on-one activity were identified, an update to all existing maps of life, and the activities calendar format and content was updated to include one-on-one activity. The agenda for residents' meetings is now developed by the activities staff visiting each resident prior to meeting and asking if they have anything they want discussed, and families are also now invited to each residents meeting. A memo of daily activity is displayed in all nurses' stations on message boards to ensure staff are aware of when and where activity is and can assist residents to attend activities. The programme ensures community involvement, with monthly guest speakers (this is an increase from every two months); and more recently, there has been an increase of supplies for Covid 19 activities to ensure residents are occupied in their rooms. Van outings were increased to two per week with staff making a commentary on each outing with history, and funny stories. There are activity focus points in each lounge area, with jigsaws and computer games to promote independent activity. Residents are encouraged to take responsibility to address each meeting and thank guest speakers/entertainers. The residents are encouraged to be aware of community events, and residents are encouraged to join with Longwood Village residents for activity when appropriate. Residents have the opportunity to attend Church, movie afternoons, RSA activities and all other appropriate activities.

		Feedback from the residents meeting expressed their appreciation of the increase in activities over the previous month – seven van outings, seven visits from musical groups, two guest speakers, visits from school children, church services on six days. Unfortunately, due to Covid 19, this has limited the ability to measure the effectiveness of the action that have been taken. Residents and relatives interviewed during the audit were complimentary of the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	In the resident long-term files reviewed the care plans are reviewed and evaluated by the registered nurse at least six-monthly or more frequently to reflect changes in health status. The service has begun multi-disciplinary reviews (MDR) with the nurse practitioner for older persons. There are short-term care plans available to focus on acute and short-term issues. These are evaluated regularly and either resolved or added to the long-term care plan as an ongoing problem. Wound care charts were evaluated in a timely manner. Care plans were updated when needs change.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referrals to other health and disability services were evident in the sampled files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. Examples of referrals sighted were to physiotherapy and hospital specialists. Discussions with the clinical manager and registered nurses identified that the service has access to GPs, ambulance/emergency services, allied health, physiotherapy, and wound specialists for advice and support.
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 documented policies and procedures in place for the management of waste and hazardous substances. Chemicals were correctly labelled and stored in locked cupboards throughout the facility. Safety datasheets and product wall charts are available to all staff. Approved sharps containers were available and meet the hazardous substances regulations for containers. Staff training on chemical safety, and management of waste and hazardous substances was evidenced. Gloves, aprons, and goggles were available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff were observed wearing appropriate personal protective clothing when carrying out their duties. Cleaning staff took cleaning trolleys into the resident rooms or they were in their line of sight so that chemicals were not left unattended, trolleys were stored in locked rooms when not in use.

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 building warrant of fitness, which expires on 30 October 2020. The maintenance person (interviewed) works 30 hours per week and is on call after hours and on weekends. There are contracted trades services to deal with any issues that arise. An organisational 52-week planned preventative and reactive maintenance programme is in place. The checking of medical equipment including hoists, has been completed annually. Electrical testing and tagging were last completed August 2020. The hot water temperatures are monitored weekly on a room rotation basis and are 45 degrees Celsius or less. The rest home and hospital area have a lounge and dining area. The corridors are wide, with handrails which promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the facility with mobility aids, where required. There is one designated smoking room within the building for the only resident who smokes. Outdoor areas are accessible for wheelchairs and walking frames. The gardens and lawns were well maintained.
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	There are two large bedrooms that have an ensuite. The remainder of the rooms have a hand basin and access to shared bathroom and toilet facilities. Privacy locks indicate whether the communal toilet/showers are vacant or in use. There is appropriate signage, easy clean flooring and fixtures, and handrails appropriately placed. Residents interviewed reported their privacy is maintained at all times.
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 bedrooms are single. The bedrooms are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Staff interviewed reported that rooms have sufficient space to allow cares to take place. All bedrooms have double leaf doors which allow access or egress of a hospital bed evacuation or ambulance trolley. A tour of the facility evidenced that residents are encouraged to bring their own pictures, photos and furniture to personalise their room.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining	FA	The service has large lounges and dining rooms for each consumer group with seating arranged to allow both individual and group activities to occur. There is adequate space to meet social distancing requirements of Covid 19 infection prevention and control managements. A large multi-purpose room is

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		available for use for activities or for family functions. All the dining rooms and lounges accommodate specialised lounge chairs as evidenced on the days of the audit. The lounge/dining rooms are accessible and accommodate the equipment required for the residents. Residents were observed moving freely around the facility and the furniture is well-arranged to facilitate this. Care staff assist or transfer residents to communal areas for dining and activities.
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	There are policies and procedures in place for equipment used by housekeeping and laundry staff. Each area has a current cleaning schedule which is maintained. Staff were observed to be wearing appropriate protective wear when carrying out their duties. Both the laundry and cleaning staff have completed chemical safety training. The housekeeper and laundry person interviewed understand outbreak management requirements. There was a high standard of cleaning maintained throughout the facility. There are dedicated cleaners working across seven days. All cleaning products are labelled. Colour coded cloths and mops are used. The cleaners' trolleys are stored in locked areas when not in use. All laundry and personal clothing are laundered on site. There are dedicated laundry staff on six days per week. There is a defined clean/dirty area within the laundry which also has an entry and exit door. Chemicals are stored securely in the laundry area. Personal protective equipment is available in the laundry and sluice room.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency/disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. All senior staff have a current first aid certificate. The facility has an approved fire evacuation scheme dated 30 May 2014. Fire evacuation drills take place every six months, with the last fire drill occurring on 16 January 2020. Smoke alarms, sprinkler system and exit signs are in place. A master folder is in place with fire education and evacuation reports, civil defence strategies including tsunami and information on emergency outbreaks. There are civil defence kits in the facility, however, records of checks are maintained. There is sufficient water stored to ensure for three litres per day for three days per resident. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup. An emergency food supply, sufficient for three days, is kept in the kitchen. Extra blankets are also available and insulation blankets are in the kit. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative

		interviews. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. Access by public is limited to the main entrance. In the event of an emergency there are extra blankets available to keep residents warm, an emergency generator for essential power and an agreement with a local contractor for the use of a larger generator.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	The facility is heated by underfloor heating and it is warm and comfortable. The internal temperatures are adjusted as necessary by the maintenance person. The building is spacious and there is adequate light and ventilation throughout the building. Residents and relatives stated the environment is comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Bupa Longwood has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the RiskMan incident reporting system and reported to head office. The clinical manager is the designated infection control coordinator who has been in the role for six years. The IC coordinator has a job description and is supported in the role by the registered nurses and care home manager. The infection control programme is reviewed by teleconference with all other infection control coordinators six monthly. Influenza vaccines are offered to residents and staff annually. Visitors and family are advised not to visit if they are unwell. There are hand sanitisers strategically placed throughout the facility. There was a respiratory outbreak reported to public health in March 2020. A case log and outbreaks meetings were held during this time. Toolbox talks were provided to staff following the outbreaks around review of processes and from learnings gained during the outbreaks. There were no follow-up actions required following the SDHB Covid audits, monitoring logs for visitors continue to be maintained for contact tracing purposes. Masks were issued to visitors on arrival to the facility. Residents newly admitted to the facility are isolated as per Bupa and MOH guidelines and policies.
Standard 3.2: Implementing the	FA	The infection control nurse has attended external infection control education through SDHB. There are

infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		monthly IC meetings (quality meeting) which include discussion and reports on infection control data. There were adequate resources to implement the infection control programme for the size and complexity of the organisation. There is advice and support from the management team, expertise at head office, infection control consultant and infection control officer at the DHB. There are adequate resources to implement the infection control programme including outbreak boxes. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. A quality goal at Longwood for 2020 was to remain under benchmark for infection control, as it was identified this had not occurred for eight months of 2019. Infection control internal audits were increased to two monthly, wound care and indwelling catheter care education sessions were provided, and infection control education was updated and current to the needs of the staff. All staff including non-clinical staff were included in the education session provided as appropriate. During the Covid period, there were Bupa posters, information and resources freely available to staff as the information became available. Education on personal protective equipment and handwashing was held along with toolbox talks at handovers. Staff completed a wellness record and declaration each shift which remains on file. A separate room has been provided for staff to change. Residents who are unwell or admitted to the service are isolated according to current guidelines. Bupa Longwood continue to maintain records of visitors and provide masks for visitors to use while in the facility. During the current level 2 restrictions, visiting has been restricted. Relatives were updated with emails or letters during the Covid lockdown period. Relatives interviewed stated the lockdown and restrictions were well managed and they felt informed and could contact the manager if they needed.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type	FA	There are Bupa organisational infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, infection control training and education of staff. The policies were developed by the Bupa organisation management team and reviews/updates are distributed by head office. Policies are discussed at staff meetings and are readily available in hard copy and on the intranet. The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.

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 infection control policy states that the facility is committed to the ongoing education of staff and residents. Annual infection control education including hand hygiene has occurred for all staff. The infection control coordinator attends handovers and provides topical toolbox talks for staff on infections and infection control practice. All new staff complete orientation which includes infection control and hand hygiene. Staff complete infection control competencies. Visitors are advised not to visit residents if they are unwell. Information is provided to residents and visitors that is appropriate to their needs and this was documented in medical records. The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice and group benchmarking. Infection control training is regularly held as part of the annual training schedule and was last held in February 2020; PPE education was held in May and in August 2020. Coronavirus education was provided in February 2020. IC competencies and toolbox talks have also been held.
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	Infection surveillance is an integral part of the infection control programme and is described in the Bupa infection control manual. Surveillance of all infections is entered into a monthly infection summary. The infection control coordinator provides infection control data, trends and relevant information to the quality, staff and RN meetings. Areas for improvement are identified, corrective actions developed and followed up. This data is monitored and evaluated monthly at head office. There are key performance indicators for all infection types. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There is close liaison with the general practitioners that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Bupa Longwood have generally maintained the goal of remaining under the benchmark. Results evidenced a decrease in infection rates with only being above benchmark on four occasions.
Standard 2.1.1: Restraint minimisation Services demonstrate that the	FA	Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint is discussed as part of staff, quality and RN meetings. Documented systems are in place to ensure the use of restraint is actively minimised. There were two residents using

use of restraint is actively minimised.		restraints in the form of bed rails and a lap belt. Seven residents were using enablers in the form of bed rails. A registered nurse is the restraint coordinator and is supported by the care home manager and clinical manager. The coordinator described strategies around restraint minimisation and assists with staff education around restraint minimisation. Staff interviews evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Education and competencies on restraint minimisation are scheduled as part of the Bupa training schedule. Three residents' files reviewed; two where an enabler was being used (bedrails) and one restraint file (low bed), both reflected an assessment and consent process had been completed with regular reviews. Residents using an enabler are monitored for safety.
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 (staff 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. Files for three residents were reviewed: one restraint and two enablers. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
Standard 2.2.3: Safe Restraint	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved

Use Services use restraint safely		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 was linked to the resident's restraint care plan including risks associated with use and care and monitoring interventions. An internal restraint audit, conducted annually, monitors staff compliance in following restraint procedures. Education on restraint was held in August 2020. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Staff were completing the monitoring forms accurately and within set timeframes.
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 are scheduled three-monthly and frequently occur with greater frequency (eg, two monthly). Restraint use is discussed in a range of meetings (quality meetings, staff meetings, and RN meetings) confirmed in the meeting minutes and during staff interviews.
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.

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.

No data to display

End of the report.