Bupa Care Services NZ Limited - Cashmere View Rest Home & Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:	Cashmere View Rest Home and Hospital
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 November 2020 End date: 20 November 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: 95

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

Cashmere View is a Bupa facility. The service provides rest home and hospital (medical and geriatric) and psychogeriatric level care for up to 103 residents. Occupancy on the day of audit was 95 residents.

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

The service is managed by a care home manager who has been in the role for three years. The care home manager is supported by a clinical manager who has also been in the role for three years. The management team is supported by the wider Bupa management team, which includes an operations manager. The residents and relatives interviewed spoke positively about the care and support provided.

The service has fully met the sub-set of standards reviewed.

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.

There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed.

Organisational management

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

Services are planned, coordinated, and are appropriate to the needs of the residents. The care home manager and clinical manager are responsible for the day-to-day operations of the facility. They are supported by two-unit coordinators/registered nurses. Goals are documented for the service with evidence of regular reviews.

Cashmere View is implementing the Bupa organisational quality and risk management system that incorporates the provision of clinical care. Key components of the quality management system link to staff meetings to keep staff informed. Quality and risk performance are reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes reflect a culture of quality improvement. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff that is specific to the role and responsibilities of the position. Ongoing education and training for staff is being implemented.

The staffing levels meet contractual requirements. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. Sufficient information is gained through the initial support plans, specific assessments, discharge summaries, and the care plans to guide staff in the safe delivery of care to residents. The care plans are personalised, and goal orientated. Care plans are reviewed every three to six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident files. There is a review by the general practitioner at least every three months.

The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. The programme encourages the maintenance of community links. There are regular entertainers, outings, and celebrations.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and accommodated. All meals and baking are cooked on site. This includes consideration of any particular dietary preferences or needs. There is a four-week rotational menu that is reviewed by a dietitian. Nutritional snacks are available 24 hours.

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 building warrant of fitness. Fire equipment is checked by an external provider. Reactive and preventative maintenance occurs with a 52-week planned maintenance programme in place.

Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained.

At the time of the audit, building renovations were underway in the hospital wing, enhancing internal spaces and outdoor safety for residents.

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 audit, there were four residents using a restraint and no residents using an enabler. Staff receive training in restraint minimisation and challenging behaviour management.

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.

There is a dedicated infection control nurse who has a role description with clearly defined guidelines. 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. The outbreaks in 2020 have been well managed. Covid19 policies and procedures have been implemented and wellness declarations continue to be completed. Adequate supplies of personal protective equipment were sighted.

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	16	0	0	0	0	0
Criteria	0	41	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using an electronic risk management register (Riskman). Documentation, including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). Discussions with residents and relatives confirmed they were provided with information on complaints. Complaints forms are in a visible location at the entrance to the facility. Three complaints have been received in 2020 (year to date). All three complaints were reviewed with evidence of appropriate follow-up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints. Feedback is provided to staff and toolbox (impromptu) talks are scheduled where indicated. Links to the Bupa operations manager, the Bupa customer relations office. Health and Disability Advocacy and HDC are provided to the complainant in the event that the complainant is not satisfied with the outcome of their complaint.
Standard 1.1.9: Communication Service providers communicate	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen accident/incident forms reviewed identified that family are kept informed. Relatives interviewed stated that

effectively with consumers and provide an environment conducive to effective communication.		they are kept informed when their family member's health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Bupa Cashmere View provides rest home, hospital (geriatric and medical) and psychogeriatric (PG) level care for up to 103 residents. Occupancy on the day of audit was 95 residents. There were 44 residents across the two PG units (full capacity). There were 8 rest home level and 43 hospital level residents in the remaining two hospital and rest home units. One unit (Ashgrove) is a dual-purpose unit with 29 beds approved for either rest home or hospital level of care. The second unit (Pioneer) is hospital level only. All residents were on the aged related residential care contract (ARCC). The Bupa organisation has documented vision and values statements that are shared with staff and are displayed. There is an overall Bupa strategic plan and risk management plan. Additionally, Cashmere View has identified a specific quality goal around full vaccination uptake (2020). Bupa health and safety goals are also identified and updated each year. These goals are regularly reviewed and are shared with staff in their monthly meetings. The care home manager at Cashmere View has been in the role for three years after previously being in the clinical manager role. The care home manager is supported by a clinical manager who oversees clinical care. The clinical manager has been in her position for three years. The management team is supported by the wider Bupa management team, which includes an operations manager. Two-unit coordinators (one PG, one rest home/hospital) support the management team. The care home manager and clinical manager have maintained at least eight hours annually of professional development activities related to managing a hospital. They attend annual Bupa forums and regional forums six-monthly.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality	FA	The quality and risk management programmes are well-established. Interviews with the managers (one care home manager, one clinical manager) and staff (two unit coordinators/registered nurses (RNs), six staff RNs (AM and PM shifts), four caregivers who work across the four units, four activities staff (two rest home/hospital; two PG), one maintenance staff, one cook) reflected their understanding of the quality and risk management systems. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff.

and risk management system that reflects continuous quality improvement principles.		The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data are discussed in staff meetings and posted in the staff room. Corrective actions are implemented when service shortfalls are identified and signed off when completed. A monthly report summarises the corrective actions. Two corrective actions discussed with the care home manager for 2020 have included building renovations in the hospital wing and improving communication with families regarding residents' activities. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews, regular toileting and individual interventions. A physiotherapist assesses all new admissions and residents who are experiencing falls. A physiotherapy assistant assists with mobility programmes prescribed by the physiotherapist. Cashmere View received the Bupa Care Home of the Year award for 2020 (out of a total of 48 care homes). An annual satisfaction survey is completed. The 2019 results demonstrated an 90% positive outcome (overall rating of quality of care) with corrective actions implemented where opportunities for improvements were identified. The 2020 satisfaction survey has recently been completed at the time of the audit and the care home manager was in the process of collating responses. The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There is a health and safety officer (maintenance person) who is supported by a team of health and safety representatives. The health and safety team meet monthly. Staff undergo annual health and safety training, which begins during their orientation. Contractors are required to be inducted into the facility by the health and safety officer and sign a health and safety information sheet when this has been completed. The hazard register is reviewed regularly. A renovation project that was underway during the audit reflected evidence of adherence to health and safety controls including restricting access to the building site. Hazard signage is visible and posted in multiple locations.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected	FA	Individual reports are completed electronically for each incident/accident, with immediate action(s) noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme. All incidents are risk rated. Resident incidents logged as high risk (severity assessment code (SAC) of three or four are escalated to the Bupa head office immediately. Fifteen accident/incident forms were reviewed across the three service areas (three pressure injuries, three skin tears, one medication error, five unwitnessed falls and three witnessed falls). Each event involving a resident reflected a clinical assessment and follow-up by a RN. Incidents are analysed to assist in the identification of trends. Neurological observations are done on all unwitnessed falls and suspected injuries to the head. The managers are aware of their requirement to notify relevant authorities in relation to essential notifications.

consumers and where appropriate their family/whānau of choice in an open manner.		Section 31 notifications made since the last audit relate to pressure injuries. A rhinovirus outbreak (March 2020) and influenza outbreak (August 2020) were notified to the public health authorities, and asbestos detected during the renovation, underway at the time of the audit, was notified to Worksafe and the City Council. Asbestos notifications were completed by the building contractors.
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 in place, including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one unit coordinator/RN, three caregivers, two staff RNs, one activities assistant) evidenced implementation of the recruitment process including (but not limited to) interviews, reference checking, signed employment contracts and job descriptions, completed orientation programmes, and annual performance appraisals. A register of practising certificates for all health professionals who work at the facility is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, caregivers, activities staff) and includes documented competencies. The caregivers, when newly employed, complete an orientation programme that has been aligned with the Careerforce health and well-being (level two) unit standards. There is an annual education and training schedule in place. The service provides regular in-service education, and sessions have been provided that address all required areas. Impromptu toolbox talks are undertaken on an as-needed (minimum of monthly) basis. Of the 21 RNs, 18 have completed interRAI training. There are 32 caregivers that work in the psychogeriatric units and 26 have completed the required specialist (PG) dementia standards. Six caregivers are in process of completing their dementia unit standards and have commenced work in the PG units within the last 18 months. A first aid trained staff is available at all times (including on residents' outings).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. Families/whānau and residents interviewed advised that there is sufficient staff on duty to provide the care and support required. The care home manager and clinical manager work full-time Monday to Friday. There are two-unit coordinators/RNs; one oversees the two psychogeriatric units and the other oversees the rest home/hospital units. They also work full time (Monday – Friday). The Palmside psychogeriatric (PG) unit (20 of 20 residents), is staffed with an RN on the morning and afternoon shifts and one RN on the night shift who shares time between the two PG units. The RNs are supported by three caregivers on the morning shift (two long shift and one short shift (0700 - 1300). One long shift and two short shift staff (1500 – 2130 and 1700 – 2100) work during the PM shift. There is a minimum of two staff in Palmside during the night shift).

		In the Barrington psychogeriatric unit (24 of 24 residents), there is a RN on duty on the morning and afternoon shifts and a shared RN on the night shift. The RNs are supported by four caregivers on the morning shift (three long and one short shift to 1300), three caregivers on the afternoon shift (two long and one short shift (1600 – 2130)), and two staff on the night shift. In the Pioneer unit (24 of 30 hospital residents), there is a RN on duty on the morning and afternoon shifts and one RN on the night shift who shares her time between the two rest home/hospital units. The RNs are supported by five caregivers on the morning shift (three long shift and two short shifts to 1300) and four caregivers on the afternoon shift (three long shift and one short shift until 2130). Two staff (one RN and one caregiver or two caregivers) are rostered on the night shift. In the dual-purpose Ashgrove unit (27 of 29 residents; 8 rest home and 19 hospital residents), there is a RN on duty on the morning and afternoon shifts and one (shared) RN on the night shift. The RNs are supported by four caregivers on the morning shift (two long shift and two short shifts to 1300) and by three caregivers on the afternoon shift (two long and one short 1600 – 2130). Two staff are rostered on the night shift.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive policies and procedures in place for all aspects of medication management. There were two residents self-administering inhalers on the day of audit, both had competencies in place which had been reviewed by the GP three-monthly. There are four medication rooms on site, all have secured keypad access. Medication fridges had daily temperature checks recorded and were within normal ranges. All medications were securely and appropriately stored. Registered nurses or senior caregivers who have passed their competency, administer medications. Medication competencies are updated annually and include syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There are no standing orders. The facility utilises an electronic medication management system. Twelve medication profiles were sampled (six psychogeriatric, four hospital level and two rest home level). All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of PRN medication administered were documented in the electronic prescription. Controlled drugs and registers align with guidelines.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's	FA	The kitchen manager oversees the procurement of the food and management of the kitchen. The service is supported by three cooks (including the kitchen manager) and a team of kitchen assistants. All food services staff have attended food safety training. There are food service manuals and a range of policies and procedures in place to guide staff. There is a well-equipped clean kitchen, and all meals are cooked on site. A current food control plan is in place expiring on 3 December 2021.

individual food, fluids and nutritional needs are met where this service is a component of service delivery.		There is an open plan lounge/ dining room in each community with a kitchenette. Meals are delivered to all four communities in a bain-marie and plated in each community by caregivers. On the day audit meals were observed to be hot and well presented. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and documented daily; these were within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen by the registered nurse or unit coordinator. Special diets were noted on the kitchen noticeboard which is able to be viewed only by kitchen staff. The national menus have been audited and approved by an external dietitian. There was evidence that there are additional nutritious snacks available over 24 hours. Facility meetings and surveys provide feedback on the meals and food service. Residents and relatives interviewed were very happy with meals provided and confirmed that alternative food choices were offered for dislikes.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses (RNs) and caregivers follow the care plan and report progress at each shift handover. All care plans reviewed included documentation that meets the need of the residents and had been updated as residents` needs changed. If external allied health requests or referrals are required, the unit coordinator's initiate the referral (eg, wound care specialist, dietitian, or mental health team). The GP interviewed on day of audit spoke highly of the service and confirmed of being kept informed of changes in resident condition. Relatives agreed that the clinical care is good and that they are involved in the care planning. Caregivers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies. Individual wound assessments, plans and evaluations demonstrate progression of healing or wound deterioration were in place for all wounds. In Ashgrove community (dual purpose) there were a total of eight wounds: four hospital and four rest home (three skin tears, two cancerous lesion, one abrasion, one chronic ulcer and one corn). Pioneer (hospital) community had eight wounds (two stage 2 facility acquired pressure injuries, one lesion, one skin tear, and one resident with four wounds (skin graft site, donor site, and two wound sites). The specialists continue to monitor progression towards healing of the graft and donor sites. Palmside (PG) community had a total of eight wounds, one resident has three skin tears, another has two skin tears. There were two residents with incontinence associated dermatitis (IAD), and another resident had an abrasion. Barrington (PG) had a total of eight wounds, including one chronic cancerous lesion, 4 cancerous lesions, one IAD and two abrasions. Wound care specialists have been involved with chronic wounds. Short-term care plans were in place for short term wounds and have either been resolved or added to the long-term care plans. Care plans document allied health input from (but not limited to), the physio, wound care specialist, podiatry. Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents. Care plan interventions clearly demonstrate that residents' needs are met. There was evidence of two

		hourly turning charts, monthly weight and vital sign monitoring, food and fluid charts and daily activity check lists. Registered nurses (RNs) and caregivers follow the care plan and report progress at each shift handover. All care plans reviewed included documentation that meets the need of the residents and had been updated as residents` needs changed. If external allied health requests or referrals are required, the unit coordinator's initiate the referral (eg, wound care specialist, dietitian, or mental health team). The GP interviewed on day of audit spoke highly of the service and confirmed of being kept informed of changes in resident condition. Relatives agreed that the clinical care is good and that they are involved in the care planning. Caregivers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies. Individual wound assessments, plans and evaluations demonstrate progression of healing or wound deterioration were in place for all wounds. In Ashgrove community (dual purpose) there were a total of eight wounds: four hospital and four rest home (three skin tears, two cancerous lesion, one abrasion, one chronic ulcer and one corn). Pioneer (hospital) community had eight wounds (two stage 2 facility acquired pressure injuries, one lesion, one skin tear, and one resident with four wounds (skin graft site, donor site, and two wound sites). The specialists continue to monitor progression towards healing of the graft and donor sites. Palmside (PG) community had a total of eight wounds, one resident has three skin tears, another has two skin tears. There were two residents with incontinence associated dermatitis (IAD), and another resident had an abrasion. Barrington (PG) had a total of eight wounds, including one chronic cancerous lesion, 4 cancerous lesions, one IAD and two abrasions. Wound care specialists have been involved with chronic wounds. Short term care plans were in place for short term wounds and have either been resolved or added to the long-term care plans. Care plans document allied health input from (but not limited to), the physio, wound care specialist, podiatry. Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents. Care plan interventions clearly demonstrate that residents' needs are met. There was evidence of two hourly turning charts, monthly weight and vital sign monitoring, food and fluid charts and daily activity check lists.
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	FA	Activities are coordinated by a team of eight. One coordinator and seven activity assistants. Two qualified diversional therapists (activities assistants,) one non-practicing occupational therapist (activities assistant) and one activities coordinator were interviewed. All members of the activity team have a current first aid certificate. On the day of audit, residents in all areas were observed being actively involved with a variety of activities. The Bupa activities programme template is designed for high-end and low-end cognitive functions and meets individual cognitive, intellectual and physical needs. The programme for each community is developed monthly and displayed in large print in all units and communal areas. Residents have an assessment and MOL (map of life) completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, family etc. Resident files reviewed identified that the individual activity plan is reviewed at least six-monthly as part of the care plan review. The residents' activity

service.		care plans have de-escalating techniques for residents with behaviour that might challenge. The activities assistants in the Ashgrove (dual purpose) and Pioneer (hospital) communities work between 9.30am to 4pm seven days a week. Activities in the Ashgrove unit include (but are not limited to), crafts, exercises, group games, and gardening. One on one activities include walks, colouring, and chats. Group games include housie, whiteboard games, sitting exercises, Christmas craft and bowls. Activities in the Pioneer community include (but not limited to); group and one on one activities depending on the abilities of the residents. There is a focus around music and singing, group games, assisting the residents with the library trolley around the facility and checking and changing the books monthly. There are daily exercises, group balloon games, crafts, story reading, housie and hand pampering. Activities in the psychogeriatric communities commence around 2pm and run until 8pm seven days a week. The programme in the Barrington community includes (but not limited to), music and group activities for the more active residents, the not so active residents or residents who prefer a calmer environment are assisted to participate in colouring, watching sport of their choosing on the TV, and playing scrabble. Group activities include housie, group ball and balloon games, exercises, karaoke and walks out in the garden. The activity programme in the Palmside community include (but not limited to), group games, planting out the garden with assistance from the activity coordinator, making bird feeders, and walks outside, 4pm drinks round, hand cares, word search, newspaper reading, and crafts in the evenings. Pet therapy and church services are provided across all communities. The van for outings is shared with sister facilities. Resident outings occur twice a month with the communities each having an outing. Special occasions are celebrated throughout the facility. Resident meetings are held regularly in the Ashgrove community, resident feedback is sought by the activities assistant on an informal basis at the six-monthly reviews with residents and relatives in Pioneer and the two PG units. Community links are maintained with visiting church groups, outings to places of interest and picnics. The service receives feedback and suggestions for the programme through surveys, monthly facility meetings and resident meetings. Residents and relatives interviewed spoke positively about the activities programme and team members.
Standard 1.3.8: Evaluation Consumers' service delivery plans are	FA	The files reviewed demonstrated that all interRAI assessments and care plans reviewed were evaluated at least six-monthly or when changes to care occurs. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. All changes in health status are documented and followed up. The multidisciplinary review involves input from the RN, GP, activities staff resident/family, unit

evaluated in a comprehensive and timely manner.		coordinator and clinical manager. The files reviewed reflect evidence of relatives being involved in the planning of care and reviews. In all the files sampled care plans have been read and signed by EPOA/family. There is at least a three-monthly review by the medical practitioner with majority of residents being seen monthly. The relatives interviewed confirmed they are 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 building warrant of fitness, which expires 1 January 2021. Fire equipment is checked by an external provider. Reactive and preventative maintenance occurs with a 52-week planned maintenance programme in place. The hot water temperatures in the resident areas are monitored regularly on a room rotation basis. Corrective actions are implemented when temperatures exceed 45 degrees Celsius. Electrical equipment is tested and tagged, and medical equipment is tested/calibrated annually. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well-maintained. There are outside areas that include seating and shade. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required. There is wheelchair access to all areas. Residents are able to bring in their own possessions and are able to decorate their room as they wish. The psychogeriatric units are secure with a secure internal courtyard. The facility has a van available for transportation of residents. Those staff transporting residents hold a current first aid certificate. The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans and necessary to provide care. At the time of the audit, building renovations were underway in the hospital wing, creating more space (merging the dining and lounge areas) and improving safety for residents wishing to go outdoors. Appropriate health and safety signage and fencing protects visitors from unauthorised access. One high risk hazard was identified (detection of asbestos). Immediate steps were undertaken to notify the authorities, remove people from the exposed area, and seal it off. Notifications were made to Worksafe and the City Council.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits assist the service in evaluating infection control needs. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. There is close liaison with the general practitioners, Bupa infection control team, DHB infection control team and laboratory that advise and provide feedback/information to the service. Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. Staff are kept informed. The facility remains under the

in the infection control programme.		benchmark for infections. The rhinovirus outbreak in March 2020, and influenza outbreak in August 2020 were managed well. Logs were maintained, daily meetings were held. The public health department was informed. Debrief meetings were held post outbreak. The Covid-19 pandemic is being well managed. During lockdown, temperature checking logs for residents and staff were maintained, and resources are available for staff. Education has been held around standard precautions, handwashing, donning and doffing personal protective equipment. Staff interviewed felt they were updated of new guidelines and legislation. Relatives interviewed described the Bupa newsletters updating them, and there was an appointment system in place for phoning the facility to talk with residents. Wellness declarations continue to be completed by all visitors and contractors entering the facility in line with current guidelines.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit the service had four PG residents using five restraints (bedrails (two), t-belts (three) and no residents using any enablers. Restraints are only used as a last resort. Staff training has been provided around restraint minimisation and management of challenging behaviours.

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.