

Bupa Care Services NZ Limited - Parkstone Care Home

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:	Parkstone Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 13 January 2022 End date: 14 January 2022
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:	88

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Parkstone is part of the Bupa group. The service is certified to provide rest home, hospital (geriatric and medical) and residential disability – physical level care for up to 102 residents. On the days of audit there were 88 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Services Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, a relative, management, staff, and general practitioner.

The care home manager and clinical manager have been in their roles for three years. The managers are supported by the operations manager and regional quality partner.

An annual quality plan has been implemented and reviewed for 2021, the 2022 plan is in draft form. The service implements the robust organisational quality programme.

The service has addressed two of the previous shortfalls around wound charts and footplates on wheelchairs. Further improvements are required around care plan interventions.

This audit has identified shortfalls around care plan evaluations, medications, and the building warrant of fitness.

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.
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The service has a culture of open disclosure. Relatives are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

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.
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There is a strategic plan and annual quality, risk management plans are in place. Plans define the scope, direction, and objectives of the service as well as the monitoring and reporting processes. The care home manager and the clinical manager provide leadership, both are registered nurses with a current practising certificate. The human resource management system is documented in policy with recruitment processes, orientation, and annual appraisals completed as per policy. There is an annual training plan that has been completed for 2021 and has been documented for 2022.

There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery for rest home and hospital level care residents. An appropriate number of skilled and experienced staff are allocated to each shift.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. A registered nurse completes initial assessments, risk assessments, interRAI assessments and long-term care plans within the required timeframes. Care plans are evaluated at least six monthly or earlier if required with input from the resident's family as appropriate. There is a review by the general practitioner at least every three months.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for administration of medicines and complete annual education and medication competencies. The medicine charts reviewed met prescribing requirements and were reviewed at least three-monthly.

A diversional therapist oversees the activity team and coordinates the activity programme for the rest home and hospital. An occupational therapist is involved in the activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual and group preferences and abilities for each resident group. Residents and the family member interviewed reported satisfaction with the activities programme.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked 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.

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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services.

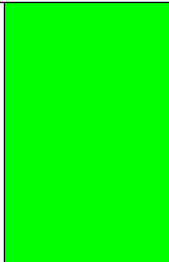
Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint and have been updated to reflect the 2021 Nga Paerewa Health and Disability standard. Policy is aimed at using restraint only as a last resort with the focus being on maintaining a restraint free environment. Staff receive regular education and training on restraint minimisation and around management of challenging behaviour. During the audit there were five residents using restraints (previously one resident using restraint and four enablers).

There is a restraint policy that includes comprehensive restraint procedures. The clinical manager (RN) is the restraint coordinator.

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.
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The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff.

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 (RN) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. The service benchmarks with other Bupa facilities. There have been two outbreaks since the previous audit, both were well managed, documented and reported accordingly. Covid preparedness includes screening of all visitors and contractors, contact tracing and evidence of vaccine status. Adequate supplies of personal protective equipment were sighted during the audit.

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	13	0	3	1	0	0
Criteria	0	39	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives on entry to the service. The care home manager continues to maintain a record of all complaints, both verbal and written, by using an electronic complaint register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. There have been three complaints logged since the previous audit (all 2021), with no complaints yet for 2022. All were appropriately managed, documented, investigated, and resolved within required timeframes.</p> <p>Discussions with one rest home and five hospital level residents (including one younger person) confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. The relative commented that the manager was very helpful and worked with the families to manage issues raised. The care home manager and clinical manager were knowledgeable around the complaint process. All staff interviewed (ten caregivers, one unit coordinator, four registered nurses (RN), one maintenance person, one cook, and one diversional therapist) could describe management of complaints in relation to their role and would direct complainants to the most senior person in charge.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>Family/whānau communication is recorded on the family/whānau communication record, which is held in each resident's file. Electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms identified family are kept informed. One rest home level</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>family member interviewed, stated that they are kept informed when their family member's health status changes and in times of Covid lockdown periods. The general practitioner (GP) stated that the service is proactive with keeping family involved. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Parkstone is part of the Bupa group of aged care facilities. The care facility has a total of 102 beds including three rooms which have been certified as double rooms. On the days of the audit, one had single occupancy and two were occupied with married couples. All rooms are suitable for rest home and hospital levels of care and communities designed to support younger people with disabilities. The service is certified for rest home, hospital (geriatric and medical) and residential disability level care (Physical).</p> <p>On the day of the audit there were 88 residents in total: 33 rest home residents including two younger persons with a disability (YPD), and one resident on a long-term support - chronic health contract (LTS-CHC). There were 55 hospital level residents including eight YPD, three funded through ACC including one respite resident, one funded through serious medical injury (SMI), and one resident on an end-of-life contract (EOL).</p> <p>Bupa's overall vision and values are displayed in a visible location. The Bupa care model is resident centred. All staff are made aware of the vision and values during their induction to the service. There is an organisational Bupa business plan and risk management plan. There are documented quality/health and safety goals that are reviewed three monthly and signed off when achieved.</p> <p>The care home manager is a registered nurse (RN) who was previously the clinical manager and has worked for Bupa for a total of 15 years. She has been in the care home manager's role for three years. She is supported by an experienced clinical manager/RN and one unit coordinator who is a registered nurse. The service has just recruited another unit coordinator to fill a vacancy. They are supported by the regional operations manager and the team at Bupa head office.</p> <p>The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service. Managers and clinical managers attend annual organisational forums and regional forums six-monthly.</p> <p>The care home manager reported a high staff turnover, especially with registered nurses (RNs) with around 40% to 50% RN turnover in the last year. The service has gone from 17 RNs to ten and are currently recruiting. There are four RNs due to start in the near future. Overall, the service has had 9.9% total staff turnover in the last year.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>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. A quality and risk management programme is documented. A quality plan is documented annually with documentation reviewed confirming that a review of the 2021 plan has been completed. Quality initiatives for 2021 included reducing pressure injuries by 10%, following review of the data, the service has reduced pressure injuries by 13% in 2021. The 2022 quality plan was in draft form at the time of the audit.</p> <p>Facility meetings held also include (but are not limited to): three monthly quality, health and safety, infection control, restraint, staff, clinical review meetings and RN meetings.</p> <p>Three-monthly quality meeting minutes sighted evidenced staff discussion around progress towards quality goals, health and safety, infection control, complaints and concerns and survey feedback. The service collates accident/incident and infection control data using the Bupa quality database. Monthly comparisons include detailed trend analysis and graphs. There is a documented internal audit programme that covers all aspects of the service. Corrective action plans are implemented where shortfalls have been identified. These have been signed off once completed and discussed at meetings. Meeting minutes reviewed evidenced discussion around all quality data collated and corrective action plans implemented.</p> <p>Satisfaction surveys were reviewed for 2019 and 2020 as the 2021 results are not yet available. The results from the residents and the relatives survey evidenced overall satisfaction with the service, with an increase of satisfaction around the building, residents' rooms, food services, and activities. An action plan was implemented around activities, staffing and food services.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The care home manager is overall responsible for health and safety. The health and safety representative interviewed (maintenance) has completed external training. The health and safety meetings are held three-monthly, where all incidents, new hazards and the hazard register are reviewed. Health and safety education commences at orientation to the service and is included in the annual education planner. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around manual handling and equipment. Staff reported they have falls prevention equipment including hospital beds, hi/low beds, sensor mats, and hoists. Training around falls prevention and management is held annually.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes.</p>

<p>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.</p>		<p>Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations are commenced when there is an unwitnessed fall, opportunities to minimise future risks were identified where possible, wound care charts and associated short-term care plans were implemented and pain assessments were completed appropriately.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been two section 31 notifications for pressure injuries sent in 2020, and six sent in 2021 (five pressure injuries including two non-facility acquired) and one fracture. There have been two outbreaks since the previous audit, one in April 2021 and one in August 2021. Both outbreaks were managed, reported, and documented appropriately.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Six staff files (one clinical manager, one registered nurse, one activities coordinator, and three caregivers) reviewed, evidenced implementation of the recruitment process, employment contracts, and completed orientation. Annual performance appraisals are currently due. A register of practising certificates is maintained.</p> <p>There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. Nine of the twelve RNs (including the clinical manager and the unit coordinator) have completed interRAI training. The RNs and clinical manager have completed syringe driver training and have access to external training. Additional education is provided via toolbox talks. The caregivers undertake Aged Care Education (Careerforce). Currently there are two caregivers who have completed level 2, eight who have completed level 3 and eight who have completed level 4. RNs attend six-monthly training through Bupa. Younger person disability training was specific to the YPD residents needs including catheters, privacy, behaviour, pain, sexuality / intimacy, person centred care and culture. All staff interviewed were able to easily identify the YPD needs separate to needs of ARC residents, especially with activities/ outings.</p> <p>Clinical staff complete competencies relevant to their role. A competency programme is in place with different requirements according to work type (e.g., caregiver, registered nurse, and cleaner). Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). Registered nurse competencies include (but are not limited to), wound, medication administration and restraint competencies.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>The staffing levels meet contractual requirements. The clinical manager shares on-call after hours with the unit coordinator and other registered nurses. The care home manager and clinical manager are available during weekdays. Adequate RN cover is provided 24 hours a day, seven days a week with at least two registered nurses on morning and afternoon shifts and at least one RN overnight. When fully staffed, there are four RNs rostered</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>morning and afternoon (two on each floor) and two (one on each floor) overnight. While RN numbers are low, the service utilises level 4 caregivers to administer medications with RN oversight.</p> <p>All beds are dual-purpose.</p> <p>Upstairs has 43 residents (19 rest home including one YPD, 24 hospital including three YPD, one resident on an end-of-life contract).</p> <p>There are six caregivers rostered in the morning shift: 4x 7 am to 3 pm, and 2x 8 am to 1 pm.</p> <p>The afternoon shift has three caregivers from 3 pm to 11 pm and two caregivers and an RN covering nightshift.</p> <p>Downstairs has 45 residents (15 rest home including one LTS-CHC, and one YPD, and 30 hospital including three ACC including one ACC respite, five YPD, and one SMI).</p> <p>Morning shift has five caregivers: 4x 7 am to 3 pm and 1x 8 am to 1 pm.</p> <p>The afternoon shift has four caregivers: 2x 3 pm to 11 pm, 1x 3 pm to 10 pm and 1x 4 pm to 10 pm.</p> <p>The night shift has two caregivers and one registered nurse overnight.</p> <p>The service is actively recruiting staff to fill vacancies, the rosters sighted evidenced all shifts were covered. The residents and relative interviewed felt the service was very complimentary of the staff and provision of cares, however, they did state they felt the facility was short staffed at times and staff were rushed. Residents felt their call bells were answered within acceptable timeframes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>Twelve medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. The facility utilises an electronic medication management system. All clinical staff (RNs, and senior caregivers) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and caregivers interviewed could describe their role regarding medication administration.</p> <p>The service currently uses robotics for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facilities four medication rooms. Medication fridges and medication rooms had daily temperature checks recorded and were within normal ranges. Effectiveness of PRN medication administered were documented in the electronic prescription. Not all eyedrops have been dated on opening or discarded within recommended timeframes. There were three self-medicating residents on the day of audit, all had competencies completed and reviewed by the GP three monthly. There is a signed agreement with the pharmacy.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Bupa Parkstone are prepared and cooked on site in a spacious and well-equipped kitchen. There is a kitchen manager who is also a qualified chef. There is a food control plan expiring 22 September 2022. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. End-cooked and serving temperatures are taken on each meal. Chiller and freezer temperatures are taken daily and are all within the accepted ranges. Cleaning schedules are maintained. All foods were date labelled in the pantry, chillers and freezers and there is an established system to ensure stock rotation</p> <p>A nutritional assessment is completed on admission and reviewed six monthly or sooner if indicated. Preferences, allergies, likes and dislikes, special diets (e.g., diabetic), and modified texture requirements are accommodated in the daily meal plan. Specialised cutlery is available and those requiring assistance are given so in a manner that maintains their dignity. A mealtime observed during the audit showed that there was sufficient time to eat in an unhurried fashion and that the dining rooms were uncluttered with space to move between the tables.</p> <p>Resident/family meetings, surveys, and one-to-one interaction with kitchen staff in the dining rooms allow the opportunity for staff/resident feedback on the meals and food services generally. There is a four-weekly seasonal menu with dietitian review and audit of menus. The menu is adapted to ensure resident's food preferences are considered. Meals are prepared in the main kitchen and sent to the four dining rooms in a temperature-controlled bain marie.</p> <p>Adapted cutlery, sipper cups and lipped plates are available for resident use. Dietary profiles are completed on admission and likes and dislikes and any changes to dietary needs are communicated to the kitchen via the RNs. A dietitian is available on request. Supplements and fortified foods are provided to residents with identified weight loss issues. The cook (interviewed) was familiar with all residents' likes and dislikes and those residents with specific dietary needs.</p> <p>One relative confirmed that there are always snacks, fruit and sandwiches available for residents to eat. The relative also reported that meals are well presented, and that staff assist those residents who require help with food and fluid intake.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Long-term care plans were documented by the registered nurse. The files sampled indicated all residents had a long-term care plan in place. Caregivers were knowledgeable about the individual resident care needs. Care plans reviewed demonstrated service integration and demonstrated input from allied health. The interRAI assessment process and a range of assessments informed the development of the residents' care plan. Resident care plans reviewed were not all reflective of the resident's needs, this is an ongoing shortfall.</p> <p>The family member interviewed reported participation in the development and ongoing evaluation of care plans. In all files reviewed there is evidence of relative/EPOA/welfare guardian involvement in care planning. Care plans reviewed provided evidence of individualised support. Short-term care plans are in use for short-term needs and changes in health status (link 1.3.8.2). Caregivers interviewed stated that the care plans were easy to follow, and</p>

		<p>residents' care needs changes (both long and short-term) are communicated to relevant staff through written and verbal handovers.</p> <p>Care plans reviewed for a YPD resident evidenced participation in management of own wellbeing and physical needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Residents' care plans are completed by the RNs. When a resident's condition alters, the RN initiates a review and if required, GP or older persons health consultation. Residents and the family member interviewed, reported their needs were being met and are satisfied with the delivery of service. There was documented evidence of relative contact for any changes to resident health status.</p> <p>A dietitian and wound nurse specialist are available by referral, a physiotherapist is contracted for six hours weekly and a podiatrist visits resident regularly. The family member interviewed stated they are kept informed of the resident's health status and have the opportunity to meet with the nurse practitioner (NP) if required.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management and the continence products that are required are identified. Caregivers and RNs interviewed stated there is adequate continence supplies.</p> <p>Adequate dressing supplies are available. Wound management policies and procedures are in place and weights are recorded at least monthly. On the day of audit, there were 43 wounds documented for both floors. The wounds included six grazes, nineteen skin tears, four chronic ulcers, three stage-one, six stage-two and one stage-three pressure injury, two blisters and two others. All wounds had plans and evaluations recording progression or deterioration of the wounds, including regular photos. Wound care specialist input was documented for chronic wounds and pressure injuries. All wound assessments were fully completed on individual plans. The shortfall related to wound management identified at the previous audit has been resolved.</p> <p>Short-term care plans were in place for short-term/acute needs, these were not always reviewed and were either resolved, ongoing or added to the long-term care plan (link 1.3.8.2).</p> <p>There is a comprehensive range of monitoring forms available for use and these have been completed as needed. Monitoring charts in use included (but were not limited to), weight and vital signs, neuro observations, blood glucose, pain, restraint, food, and fluid, turning charts and behaviour monitoring as required. Monitoring forms evidenced that the required observations were being completed in the prescribed timeframes.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as</p>	FA	<p>A qualified diversional therapist and two activities coordinators work on a four on, two on rotation from 9 am to 4.30 pm covering a seven-day week. The two activities coordinators are completing their diversional therapy training. The Bupa Southern Regional occupational therapist oversees the activity programme, and meetings with the</p>

<p>part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>activity staff occur six-weekly.</p> <p>Activities are divided into upstairs and downstairs communities and follow the same programme. A monthly programme is developed, and a detailed weekly programme is distributed to all residents and posted on noticeboards. Residents are encouraged to participate in a range of group activities such as exercises, walk and talk, bowls, and card and ball games, quiz and chat sessions, pet therapy and happy hour. There are weekly drives/outings for residents to places of interest, fortnightly church services and regular entertainer visits. There are resources available for care staff to use when activities staff are not available. Activities are offered to meet the cognitive, physical, intellectual, and emotional needs of the residents.</p> <p>On the days of audit, residents in all areas were observed being actively involved with a variety of activities with support and involvement of staff. Staff could describe how YPD residents on disability contracts participate in a range of community events and activities consistent with their needs.</p> <p>An activity profile and “Map of Life” is completed on or soon after admission in consultation with family input (as appropriate). Socialising and activity plans were incorporated into the long-term care plan and reviewed six-monthly at the same time as the care plans. Resident and family meetings are held bi-monthly, and residents were observed to engage in a variety of activities offered. The family member interviewed spoke positively about the activities programme.</p> <p>Younger People with a Disability:</p> <p>There is a focus on providing individual activities for the younger residents. Activities include one-on-one with the residents around specific interests, special movies and outings including ten pin bowling, shopping trips, cafés, and community outings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>In the residents' files reviewed, all initial care plans have been documented and evaluated by the RN within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes (link 1.3.5.2) in five of the six files reviewed. One resident had been at the facility for less than six months. In the files reviewed, evaluations did not always document progress towards meeting goals and not all sections of the care plan were evaluated. There are short-term care plans available to focus on acute and short-term issues. Wound care charts were evaluated in a timely manner.</p> <p>The multidisciplinary review involves the RN, GP, activities staff, resident, relatives, unit coordinator and clinical manager. The files reviewed reflected evidence of relatives being involved in the planning of care and reviews. The family are invited to attend and/or notified of the outcome. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes. In the files sampled care plans have been read and signed by either the resident (where appropriate) or the relative. There is at least a three-monthly review by the GP with the majority of residents being seen monthly. The relative interviewed confirmed they are invited to attend the</p>

		multidisciplinary care plan reviews and GP visits.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The current warrant of fitness expired on 1 October 2020, due to delays related to Covid-19. Fire equipment is checked by an external provider. The maintenance person interviewed described the reactive and preventative maintenance programme. There is a 52-week planned maintenance programme in place. Electrical equipment has been tested and tagged. Hot water temperature is monitored weekly in resident areas and at hot water cylinders. All wheelchairs had foot plates attached addressing the partial attainment from the previous audit.</p> <p>The corridors are wide enough around the facility and handrails are available to promote safe mobility. Residents were observed moving freely around the facility with mobility aids where required. There are areas to wander inside and outside with well-maintained garden areas and courtyards. Seating and shade are provided.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and laboratory that advise and provide feedback/information to the service.</p> <p>Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control nurse. This includes internal audits of the facility, hand hygiene spot checks and competencies and surveillance of infection control events and infections. Surveillance data is available to all staff. Infection statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.</p> <p>There have been two outbreaks since the previous audit in April (unconfirmed norovirus) and August (respiratory) 2021. Both outbreaks were well managed. All notifications were made appropriately to the public health team, a section 31 notification was made, and Ministry of Primary Industries (MPI) were notified for the unconfirmed norovirus outbreak. The MPI and DHB were satisfied with the processes and investigations. Daily logs were maintained and meetings with staff were held daily. A debrief meeting was held for both outbreaks.</p> <p>The service has process and procedures implemented to manage the risk posted by Covid-19. Bupa implemented teleconferences during Covid-19 lockdown to ensure staff have the most up to date information; these are now approximately monthly. Additional education has been provided around personal protective equipment (PPE) and 100% of staff have attended.</p> <p>All residents are screened using the Covid-19 screen form prior to admission. New residents are isolated for 14 days following admission. All visitors and contractors are required to complete a health questionnaire and provide proof of vaccination status at reception. All visitors and contractors must scan the QR code for contact tracing</p>

		purposes. Adequate supplies of personal protective equipment were sighted during the audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Bupa have been reviewing and updating policies in line with the Nga Paerewa 2021 health and disability standards. Bupa have reviewed all restraints and enablers and removed the wording 'enablers' from the policy as from January 1st.</p> <p>The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is. The new, Nga Paerewa 2021 restraint standards are being implemented and implementation is planned to be reviewed through internal audits, facility meetings, and regional restraint meetings and at an organisational level.</p> <p>Internal audits and education have been held in 2021 around restraint. The last audit in September 2021 had 92% compliance rate. Restraint education was held in July, and November in 2021. Interviews with the staff confirmed their understanding of restraints.</p> <p>On the day of the audit there were five residents using restraints (bedrails), four of these were previously enablers. There was evidence of discussion with families, assessments identified risks, and consents were appropriately signed. Restraints are reviewed three-monthly by the GP. Monitoring forms are maintained. Quarterly meetings are held to discuss and review all restraints.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	The service uses an electronic medication management system. All medicines are stored securely in locked cupboards or trolleys in secure treatment rooms.	Not all eyedrops were dated on opening or were in use past the expiry date.	<p>Ensure all eyedrops are dated on opening and disposed of according to manufacturer's instructions.</p> <p>30 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired</p>	PA Moderate	Long-term care plans were documented by the registered nurse. All residents had a long-term care plan in place. Caregivers were knowledgeable about the individual resident care needs. Registered nurses undertake a risk assessment for all residents	i) Three of six care plans (one rest home and one hospital) had not been updated to reflect changes around mobility, and the	i) Ensure care plans are reflective of current

<p>outcomes identified by the ongoing assessment process.</p>		<p>however, interventions were not documented for all assessed care needs, and not all interventions in use had been documented in the care plan.</p>	<p>care plan for the hospital resident did not have social changes updated in the care plan.</p> <p>ii) One rest home resident care plan did not include management of bladder spasms.</p> <p>iii) Two hospital residents with diabetes did not include signs and symptoms or management of hypo and/or hyperglycaemia.</p> <p>iv) Mobility interventions were not consistently documented for three hospital residents including a double amputee and two residents with changes in mobility.</p> <p>v) Interventions were not fully documented for two hospital residents assessed at moderate or high risk of risk of pressure injury.</p> <p>vi) Interventions were not documented for one hospital resident with a supra-pubic catheter.</p>	<p>evaluations.</p> <p>ii) - vi) Ensure Interventions are documented for all identified needs.</p> <p>60 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response</p>	<p>PA Low</p>	<p>All care plans requiring evaluation had current documentation; however, the documentation did not always include progress against the goals. Evaluations were documented by section, however</p>	<p>(i) Five of six care plans sampled (two rest home and three hospital including one on an ACC contract</p>	<p>(i) Ensure all evaluations document progress</p>

<p>to the support and/or intervention, and progress towards meeting the desired outcome.</p>		<p>not all sections had been evaluated. Short term care plans are used for acute and short-term issues, however not all short-term care plans had been evaluated regularly.</p>	<p>and one on a YPD contract) did not document progress towards goals.</p> <p>(ii) One short term care plan for a hospital resident with pressure injuries had not been evaluated for six weeks.</p>	<p>towards meeting goals.</p> <p>(ii) Ensure short term care plans are evaluated regularly.</p> <p>(iii) Ensure all sections of the care plan are evaluated six-monthly.</p> <p>60 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>There have been delays in building inspections due to Covid restrictions. The inspection when held, identified required remedial work. The repairs were delayed as a result of tradesman availability over the Christmas break and are in progress.</p>	<p>The current building warrant of fitness expired on 1 October 2021.</p>	<p>Provide evidence of a current building certificate.</p> <p>60 days</p>

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, there 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.