

Bupa Care Services NZ Limited - Glenburn Rest Home & Hospital

Introduction

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

The audit has been conducted by 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: Glenburn Rest Home & Hospital

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

Dates of audit: Start date: 3 February 2022 End date: 4 February 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: 94

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

Glenburn Rest Home and Hospital is part of the Bupa group. The service is certified to provide hospital (medical, geriatric); psychogeriatric, rest home and dementia level care for up to 103 residents. On the day of the audit there were 94 residents.

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

The general manager at Glenburn is an experienced manager (RN) who has been newly employed in the role. There are systems being implemented that are structured to provide appropriate quality care for residents. An orientation and in-service training programme are established that provide staff with appropriate knowledge and skills to deliver care. Residents and family advised that the staff provide a caring and homely environment.

This certification audit identified that improvements are required in relation to the complaints process, the quality system, resident assessments, care plans and interventions.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code of Rights and services is readily available to residents and families. Annual staff training supports staff understanding of residents' rights. Care plans accommodate the choices of residents and/or their family/whanau. There is a Māori health plan supporting practice. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Complaints processes are established. Residents and family interviewed confirmed their understanding of the complaints process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative newsletters. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Quality initiatives are implemented which provide

evidence of improved services for residents. There are four benchmarking groups across the organisation focusing on rest home, hospital, dementia, and psychogeriatric/mental health services. Glenburn is benchmarked in all of these. There are human resources policies to guide practice and an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme established that includes Inservice and online learning. External training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is an admission pack that provides information on all levels of care. 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 resident, and goal orientated. Care plans are reviewed every six months or earlier if required. Files reviewed identified integration of allied health and a team approach is evident in the overall resident file. 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 resident groups. The programme encourages the maintenance of community links. There are regular entertainers, outings, and celebrations. Activities are focused on meaningful and sensory activities in the dementia care and psychogeriatric units.

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.

All meals are provided on site. There is a current food control plan in place. Resident dietary needs are met, and alternative foods offered for dislikes. There are nutritious snacks 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.
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The building has a building system status report and emergency evacuation plan in place. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. Cleaning and laundry services are well monitored through the internal auditing system. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge and dining areas throughout the facility in addition to its main communal areas in each wing. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible and secure for the wings that require this. Emergency systems are in place in the event of a fire or external disaster. There is an approved evacuation scheme and emergency supplies for at least three days. At least one first aid trained staff member is on duty 24/7 and on outings.

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.

There is a restraint policy that includes comprehensive restraint procedures. The process for the assessment and evaluation of enabler use is the same as restraint and included in the policy. The service had 15 hospital level residents using restraint and one resident using an enabler. Restraint includes bedrails, seating restraint and hand holding. Review of restraint use across the group is discussed at regional restraint approval groups and in facility meetings. Staff are trained in restraint minimisation and restraint competencies are completed annually.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control and regular Covid-19 updates.

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	45	0	1	4	0	0
Criteria	0	96	0	1	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are made available to residents and their families. Policy relating to the Code is implemented. Three managers (one general manager, one clinical manager, one regional operations manager) and nineteen staff interviewed (seven caregivers including two rest home, two dementia/psychogeriatric and three hospital; five registered nurses (RNs) including one unit coordinator (rest home/hospital), one regional quality partner, one activities coordinator, one maintenance, one kitchen manager, one laundry, one physiotherapy assistant and one housekeeper) could describe how the Code is incorporated into their job role and responsibilities. All staff receive training about the Code during their induction to the service. This training continues annually through the staff education and training programme.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information	FA	The service has in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident in all ten resident files reviewed. There was evidence of general practitioner (GP) completed and signed clinically not indicated resuscitation status. General consent forms were evident on files reviewed. Family discussions were evident in the whānau contact form and progress notes. Discussions with registered nurses and caregivers confirmed that they are familiar with the requirements to obtain informed

they need to make informed choices and give informed consent.		<p>consent for personal care, entering rooms and so on.</p> <p>All long-term resident files had signed admission agreements. The enduring power of attorney (EPOA) had been activated in the files reviewed of dementia care and psychogeriatric care residents. The respite care resident had a short-term admission agreement.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code and information about advocacy services on entry. The pamphlet is included in the welcome pack.</p> <p>Interviews with care staff confirmed that residents and relatives are informed, and this was confirmed also by relatives and residents interviewed. Interview with residents confirmed that they are aware of their right to access advocacy. Interview with family members confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. In the files reviewed there was information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents may have visitors of their choice at any time although visiting hours have been restricted during Covid lockdowns. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents can participate in as much as they desire and can safely do.</p> <p>Resident meetings are held at regular intervals with family invited to attend. There are also family forums held regularly throughout the year.</p> <p>The service encourages the community to be a part of the residents' lives in the service with visits from entertainers.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>There is a complaints procedure to guide practice. The general manager has overall responsibility for managing the complaints process at Glenburn. The complaints procedure is provided to resident/relatives at entry and also around the facility on noticeboards. There is a 'post box' at reception where complaints can be posted with this cleared daily Monday to Friday.</p> <p>Two complaints have been lodged in 2022 (year-to-date) with one of the two complaints lodged with HDC (18 January 2022). The general manager, with support from the regional operations manager and the Bupa head office, is compiling a response to HDC that is due on 9 February 2022. The second complaint includes evidence of acknowledgement and a full investigation although closure of the complaint is pending.</p> <p>Ten complaints were lodged in 2021. Quality meeting minutes reflect evidence of additional complaints</p>

		<p>being lodged but these were not sighted in the electronic complaints register. Four complaints lodged in 2021 were reviewed. Missing was documented evidence of a full investigation although both complaints reviewed were signed off as resolved. The general manager stated that the detail relating to each complaint had not been downloaded into the electronic database (Riskman). This occurred prior to her employment as the general manager.</p> <p>Complaints received have been trended but there were no corrective action plans to address these trends (link 1.2.3.8).</p> <p>Discussion with residents and relatives confirmed they were provided with information on the complaint process. Complaint forms were visible for residents/relatives in various places around the facility.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The information pack provided to residents on entry includes information on how to make a complaint, and information on advocacy services and the Code. There is the opportunity to discuss these services prior to and during the admission process. Residents (five including three from the hospital – two identified as a young person with disabilities, and three from the rest home including one on respite) and three relatives interviewed (one psychogeriatric (PG), one dementia, one hospital) confirmed information has been provided around the Code and the complaints process. Large print posters of the Code and advocacy information are displayed in the facility in English and te reo Māori.</p> <p>Residents and families interviewed confirmed that they have been informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p> <p>The resident meetings and family forums are an opportunity for residents and family to discuss application of the Code and for staff to confirm access to advocacy services. These meetings were restricted in 2021 during periods of Covid lockdowns.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and then integrated with the residents' care plan. There was evidence of family involvement.</p> <p>Privacy signage is present on all toilet and shower doors. Care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and they confirmed that they do not hold personal discussions in public areas. The residents and families interviewed confirmed that residents' privacy is respected. A tour of the facility confirmed there is the ability to support personal privacy for residents. The residents' personal belongings are used to decorate their rooms. Caregivers reported that they promote the residents' independence by encouraging them to be as active as</p>

		<p>possible.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service.</p> <p>Residents and family interviewed confirmed that they are encouraged to access services in the community where able. Spiritual needs are individually identified as part of the assessment and care planning process and were documented in the resident files reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is an organisational Māori health plan that aligns with contractual requirements. There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The Bupa Māori health policy was first developed in consultation with kaumātua and is utilised throughout Bupa's facilities. The service can access kaumātua and the kuia through Te Kawerau a Maki.</p> <p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the resident. There is one resident living at the facility who is Māori but does not identify with this culture. Staff interviewed could describe how they refer to the care plan and ways in which cultural beliefs are upheld. There are Māori staff available to speak to residents in te reo Māori.</p> <p>Family/whānau involvement is encouraged in assessment and care planning. Visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service provides a culturally appropriate service by ensuring it understands each resident's preferences and where appropriate their family/whānau. Values and beliefs have been discussed at the initial care planning meeting and then incorporated into the care plan. Six monthly multi-disciplinary team meetings are scheduled to assess if needs are being met. Family is invited to attend. Family assist residents to complete 'the map of life' which identifies interests and social likes. Staff stated that the map of life gives them a basis for discussion and as a reminder for them around cultural needs.</p> <p>Discussions with residents and relatives informed values and beliefs are considered. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p> <p>There was one resident with very limited English. There are staff on site who can speak this resident's language, and the service makes every attempt to put staff members with the resident to provide cares.</p>

		Staff can access interpreting services if required through a nationwide interpreting service.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>There are implemented policies and procedures to protect clients from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions. The Code of Conduct is included in the employee pack. Staff interviewed demonstrated an awareness of the importance of maintaining professional boundaries with residents.</p> <p>Residents interviewed stated that they have not experienced any discrimination, coercion, bullying, sexual harassment or financial exploitation. Professional boundaries are reconfirmed through education and training sessions and staff meetings, and managers stated that performance management would address any concerns if there was discrimination noted.</p> <p>Interviews with staff confirmed an understanding of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Services are provided at Glenburn that adhere to the health and disability services standards. There is an organisational policy and procedure review committee to maintain currency of operating policies. All Bupa facilities, including Glenburn, have a master copy of policies and procedures as well as related clinical forms.</p> <p>There have been changes in the management team since the last audit. The current general manager joined Bupa in November 2021, shortly followed by a new clinical manager in January 2022.</p> <p>Since their last audit a number of improvements have been made including (but not limited to): improving the way education is delivered with a new large screen tv in the training room; the rest home decking area has been modernised with new decking and awnings for both resident rooms and for use directly from the lounge area – providing a safe, private and secure shaded seating and garden area has been created with a sail providing a comfortable environment for the residents in the warmer months; the pond and rockery garden has been made with great easy, gently sloped access allowing another beautiful space; new equipment has been purchased e.g., sensor mats and bariatric mattresses; and all three treatment rooms have been upgraded to include air conditioning units.</p> <p>There is a well implemented education programme with staff also supported through regular 'toolbox' talks. These are often in response to queries raised or where corrective actions have been identified. A number of core clinical practices also have education packages for staff which are based on their policies.</p> <p>Quality data is completed and documented electronically using Riskman software. The clinical indicators are analysed at Glenburn. Information is provided to staff on the trends.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an incident reporting policy to guide staff on their responsibility around open disclosure. Fifteen incident forms reviewed identified that family had been notified following a resident incident. Relatives interviewed stated that they are informed when their family members health status changes.</p> <p>There is an interpreter policy and contact details of interpreters are available. Managers described accessing interpreting services when required.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The information pack is available in large print and this can be read to residents.</p> <p>Information specific to the psychogeriatric and dementia community is provided to family on admission as part of the admission pack. The managers and registered nurses described discussing the philosophy of the dementia community and psychogeriatric community with relatives when they enter the service, and this was confirmed by relatives interviewed. Additional information is available if required.</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>	FA	<p>Glenburn is a Bupa facility which provides hospital, rest home, dementia and psychogeriatric level care for up to 103 residents. Occupancy on the day of audit was 94 residents.</p> <p>There are 26 rest home level beds with an occupancy of 23 on the day of audit; 52 hospital level beds with an occupancy of 50; 12 dementia level beds with an occupancy of 11; 13 psychogeriatric (PG) level beds with an occupancy of 12. There are no dual-purpose beds.</p> <p>Residents included four young people with a disability (YPD) who have been assessed as requiring hospital level of care by Taikura Trust; one resident (hospital) on ACC and one resident (rest home) on respite. The PG level residents are funded through the age residential hospital specialised service (ARHSS) contract. The remaining residents were on the age-related residential care (ARRC) contract.</p> <p>The philosophy of the service includes providing safe and therapeutic care for residents requiring specialised hospital level care (psychogeriatric), dementia care, rest home care and hospital care. Resident care plans reflect the service's resident centred approach to care and support. Bupa has identified six key values that are displayed on the wall at Glenburn. There is an overall Bupa business plan and risk management plan and a documented purpose, values, and direction. Goals are regularly reviewed, evidenced in the quality meeting minutes. New goals for 2022 were being established at the time of the audit.</p> <p>The general manager at Glenburn is an experienced manager (RN) who has worked in aged care since</p>

		<p>1982. She was appointed to her role on 8 November 2021 and is responsible for both the care centre and retirement village. Prior to accepting this role, she was a quality and risk manager for another aged care facility for five years. The manager is supported by a clinical manager (registered nurse) who oversees clinical care and was appointed only two weeks prior to the audit (January 2022). The clinical manager holds three years of aged care experience as an RN including work as a unit coordinator at another facility. HealthCERT has been informed via Section 31 reports regarding these changes in management. The managers are supported by the wider Bupa management team that includes an operations manager and quality partner, both who were onsite during the audit.</p> <p>Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual forums and regional forums six monthly. The managers have maintained at least eight hours annually of professional development activities related to management of services such as these.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence, the clinical manager provides covers the general manager's role, supported by the operations manager. The operations manager confirmed that they increase the amount of time they are on site if the care home manager is on leave. A relieving manager is available for extended absences. The service has operational management strategies and a quality improvement programme to minimise risk of unwanted events.</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>	PA Moderate	<p>Glenburn has established the Bupa quality and risk management system which is designed so that key components are linked to facility operations. Policy review is coordinated by Bupa head office. The service has comprehensive policies/procedures to support service delivery including a policy around meeting interRAI requirements. A document review process is in place.</p> <p>The quality programme includes an annual internal audit schedule that is being implemented at Glenburn. The majority of internal audits indicate evidence of a corrective action plan although two of twelve audit reports reviewed in 2021 (call bell audits) were missing evidence of corrective action plans either being established and/or implemented.</p> <p>Meetings include (but are not limited to): head of department, quality, health and safety, infection control, staff meetings; clinical review meetings. Meetings serve as forums to review progress towards goals. The frequency of meetings has been impacted by Covid lockdowns in 2020. Glenburn participates in the organisation's benchmarking programme that monitors key aspects of care. Discussions with registered</p>

		<p>nurses and caregivers confirmed their involvement in the quality programme. Quality meeting minutes identified trends for complaints although there were no corrective action plans established to address these trends.</p> <p>Resident/relative meetings are held. There is an annual satisfaction survey completed. The 2020 report from the survey confirmed 96% of residents were either neutral (29%) or satisfied (67%) with the services being delivered. This rating dropped in 2021 to 87% (42% neutral and 45% satisfied). Corrective actions to address concerns/low scores were not documented.</p> <p>The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place, including accident and hazard management. Staff are contractors are orientated to health and safety processes. The hazard register is regularly reviewed. Evidence was sighted of hazard report forms being completed and actioned.</p> <p>Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. This includes strategies to minimise falls for each resident (e.g., physiotherapy intervention, sensor mats and intentional rounding). Care staff are informed during handover of residents who had either fallen or were at risk of falling.</p>
<p>Standard 1.2.4: Adverse Event Reporting</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>	FA	<p>The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. Fifteen electronic adverse event forms reviewed (witnessed and unwitnessed falls, skin tears) indicated that there were completed and reviewed by the clinical manager and signed off. Monthly analysis of incidents by type is undertaken by the service and reported to the various staff meetings. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Neurological observations are completed as per policy for any resident with a fall involving a head injury or for an unwitnessed fall.</p> <p>The general manager is aware of the requirement to notify relevant authorities in relation to essential notifications. Section 31 reports completed for 2021 included one suspected outbreak, three pressure injuries (grade 3 or unstageable), and two residents who absconded with one who required police involvement.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with</p>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development.</p> <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and skills. A register for current practising certificates is maintained for internal and external health professionals. Eleven staff files were reviewed (one clinical manager, one unit</p>

<p>good employment practice and meet the requirements of legislation.</p>		<p>coordinator/RN, four RNs, four caregivers, one clinical manager) and included signed employment contracts or links to a collective agreement, reference checking, police vetting and acknowledgement that staff have been provided with a job description. Job descriptions were sighted for the various roles for the Bupa organisation.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Evidence of completed orientation manuals were sighted in the staff files reviewed. Annual appraisals are conducted for all staff. There was a completed in-service calendar for 2020 which exceeded eight hours annually. A 2021 education calendar has been established. A range of competencies are completed annually, determined by the job role and responsibilities.</p> <p>Sixty caregivers are employed, which includes five casual staff. Seventeen have completed their level four qualification and six have completed their level three qualification. There are a total of 23 caregivers who work in the dementia and PG units. Twenty-two have completed the required NZQA dementia standards with one staff newly employed and enrolled. There are four of the staff working in the PG unit employed for over 18 months. There was one unit standard that is required by staff as part of working within the PG unit that had not been completed. Bupa have been discussing pathways with Careerforce so that the unit standards as prescribed in the ARHSS and the ARCC are covered by staff as they progress through their qualifications. Careerforce offer several moving and handling unit standards and organisations have selected a unit standard to augment the training done within the organisation. Our staff were undertaking a moving and handling unit standard as part of their qualification along with their annual training and competency; however the unit standard wasn't the specific one that was noted in the ARHSS agreement so that change has now been made by Bupa.</p> <p>Fourteen RNs and three enrolled nurses (ENs) are employed. Eight have completed their interRAI qualification. Twenty-four staff hold current first aid certificates, including activities, kitchen, RN's and a selection of caregivers.</p> <p>The clinical manager and registered nurses attend external training including conferences, seminars and sessions provided by Bupa and the local district health board as sighted in staff files reviewed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	<p>FA</p>	<p>The staffing levels meet contractual requirements. The general manager, clinical manager and two unit-coordinators are rostered Monday – Friday. On call (one clinical manager and one care home manager or GM) is shared with seven other Bupa sites. Adequate RN cover is provided 24 hours a day, seven days a week. Agency and casual staff are utilised to cover staff absences.</p> <p>At the time of the audit there were two full-time RN vacancies, and all caregiver positions were filled. Three</p>

<p>and/or experienced service providers.</p>		<p>enrolled nurses (ENs) (two permanent and one casual) occasionally replace the rostered RN in the RH/hospital wings. A unit coordinator is rostered for dementia/PG and the hospital wing on the upper level (Rata). The second unit coordinator is responsible for the hospital wing on the lower level (Kowhai) and the rest home wing.</p> <p>The dementia and PG wings are adjacent to each other with a nursing station between the two units. Glass windows in the nursing station provides visual access to both areas.</p> <p>One RN is rostered across all three shifts to cover both dementia and PG.</p> <p>Caregiver staffing in the dementia and PG units: Koru/dementia (11 residents): AM: one long shift (eight-hour shift) and one short shift to 1400; PM: one long shift and one short shift to 2000; Night: one long shift. Koru/PG (12 residents): AM: two long shift and one short shift to 1300; PM: one long shift and two short shift (to 2100 and 1600 to 2000); Night: one long shift.</p> <p>One RN or one EN is rostered 24/7 for each hospital wing. The RN covering the hospital wing on the ground floor oversees residents in the rest home wing.</p> <p>Caregiver staffing in the rest home wing: Manuka/rest home (23 residents): AM: two long shift; PM: one long and one short shift; Night: one long shift.</p> <p>Caregiver staffing in the hospital wings: Kowhai/hospital (26 residents): AM: three long shift and two short shift (to 1230 and 1330); PM: two long shift and two short shift (to 2000); night: one long shift. Rata/hospital (22 residents): AM: three long and two short shift (to 1230 and 1330); two long shift and two short shift (to 2000); night: one long shift.</p> <p>Interviews with staff confirmed that they are working longer shifts and there are times that staff are shifted to work in other areas, which can be stressful. A pager system allows for them to call for assistance if needed. Interviews with residents and families also confirmed that staff appear very busy but that the staff do go out of their way to meet the residents' needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry, into the resident's individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files were protected from unauthorised access by being held in locked cupboards.</p> <p>Care plans and notes are legible and where necessary signed and dated by a registered nurse. Entries are legible, dated and signed by the relevant caregiver or registered nurse including designation. Individual resident files demonstrate service integration.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and procedures in place to safely guide service provision and entry to services. Referring agencies establish the appropriate level of care required prior to admission of a resident. Information gathered at admission is retained in resident's records. Relatives interviewed stated they were well informed on admission and had the opportunity to discuss the admission agreement with the manager. The service has a well-developed information pack available for residents/families/whānau at entry, including admission to the dementia and PG units. An advocate is available and offered to family.</p> <p>The admission agreements reviewed aligned with the requirements of the ARC and ARHSS contract. The ten admission agreements viewed were signed. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. A Bupa transfer form, copy of the resident admission form, most recent GP consultation notes and medication information accompanies residents to receiving facilities and communication with family is made.</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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management. There were no residents self-administering on the day of audit. There are four medication rooms on site, all of which have secured keypad access. Medication fridges and rooms had daily temperature checks recorded and were within normal ranges. All medications were securely and appropriately stored. Registered nurses, enrolled 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. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The service does not use standing orders.</p> <p>The facility utilises an electronic medication management system. Twenty medication profiles were sampled, and 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 medications administered were documented in the electronic prescription.</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>	FA	<p>The service has a head chef/kitchen manager who oversees the procurement of the food and management of the kitchen. She is supported by two cooks and four kitchen assistants. All staff have food hygiene certificates. There is a well-equipped kitchen, and all meals are cooked on site. Meals are delivered to the rest home (Manuka) in a bain-marie and plated in the unit kitchenette by caregivers. The psychogeriatric and dementia unit (Koru) and Rata have their meals plated and delivered in hot boxes. These are also served by caregivers. Meals in Kowhai (hospital) are served directly from the kitchen counter by kitchen assistants. Meals taken to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be hot and well-presented, and residents stated that they were enjoying their meal. Staff were observed assisting residents with their midday meals.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. These were all within safe limits. Food temperatures are checked (including the reheated evening meal) and these were all within safe limits. The registered nurses complete a resident's nutritional profile on admission, which identifies dietary requirements and likes and dislikes, a copy is provided to the kitchen. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on the kitchen noticeboard for kitchen staff to access at all times. The service uses individually moulded puree foods for those residents who require it. The four-weekly menu cycle is approved by the Bupa dietitian. There was evidence that there are additional nutritious snacks available over 24 hours. Residents and families interviewed expressed satisfaction with the meals provided. There is a current food control plan expiring 22 September 2022 and the service had just been awarded a local council 'A' grade rating.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reasons for declining service entry to potential residents should this occur and communicates this to potential residents/family/whānau. The reasons for declining entry to the service would be if there are no beds available. Potential residents would be referred back to the referring agency if entry were declined.</p>
<p>Standard 1.3.4: Assessment</p>	PA	<p>The service has policies requiring personal needs information is gathered during admission in consultation</p>

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	Moderate	<p>with the resident and their relative (as appropriate); however, not all assessments had been completed as per policy requirements. InterRAI assessments were completed in all long-term resident files reviewed apart from one rest home resident who had not been in the service for 21 days. Bupa assessment booklets and an interim care plan were completed on eight of ten resident files within 24 hours of admission. Personal needs, outcomes and goals of residents were identified in the eight completed. Resident files reviewed demonstrated that a range of assessment tools were completed in the majority of resident files and reviewed at least six monthly including (but not limited to); falls, pressure areas and continence. Vital signs and weights were monitored on a weekly to monthly basis dependant on needs. Behaviour assessments had been completed for the dementia care and psychogeriatric files reviewed. Assessments were conducted in an appropriate and private manner. The outcomes of assessments formed the basis of the long-term care plans.</p> <p>Assessment processes and the outcomes are communicated to staff at shift handovers through verbal and written shift reports, progress notes and care plans. Residents (rest home and hospital) and family interviews stated they were involved in the assessment process on admission and on an ongoing basis.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care in the majority but not all of the resident records reviewed. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the mental health for older persons team, physiotherapist, dietician, and wound care specialist. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents occurs.</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>	PA Moderate	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and the continence products that are required are identified. Specialist continence advice is available by referral if required.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary</p>

		<p>requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included chronic skin conditions, skin tears, cancerous lesions, and wounds classed as 'other' which includes ingrown toenails, blisters etc. There was one facility acquired grade 1 pressure injury, two grade 2 facility acquired, and two grade 3 facility acquired pressure injuries for which section 31 notifications had been submitted. There was evidence of wound nurse specialist involvement in chronic wound and pressure injury management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds and neurological observations; however, monitoring was not always fully documented as required by the care plan.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is one activity coordinator (40 hours weekly), one activities assistant (35 hours weekly) working Monday to Friday that coordinate and implement the programme for the facility. On weekends the caregivers use an activities box that contains DVDs, games and music for resident activities. The activity coordinator and activities assistant have completed dementia training (one is in the process of completing DT training). The service has employed an activity coordinator who has a Diversional Therapist qualification and will be able to provide some part time support until the permanent move to Bupa Glenburn takes place in three weeks. The activity coordinator and assistant share duties and rotate between rest home, hospital and dementia/PG unit.</p> <p>The Bupa activities programme template is designed for high-end and low-end cognitive functions and caters for individual needs. There are three separate activity calendars, one for Manuka & Kowhai communities combined, one for Koru and one for Rata. Activities take in to account the abilities of the residents and focus upon meaningful and sensory activities in the dementia care and psychogeriatric units (Koru community).</p> <p>There is a weekly programme in large print on noticeboards in all unit lounges. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. One on one activities are particularly in evidence in the psychogeriatric unit where residents' concentration spans are often short. Activities include daily morning exercises, games, quizzes, music, sensory games and walks outside. The residents play bingo and bowls in the lounges. On the days of audit, residents were observed participating in exercises, reading in the library, using exercise equipment and listening to, then discussing the news of the day. There are interdenominational church services held in the facility monthly (not during</p>

		<p>the red Covid traffic light setting). There are weekly van outings to the local park, beaches and a nearby farm. The activities staff & van driver have current first aid certificates. There are regular entertainers visiting the facility (subject to Covid restrictions).</p> <p>Special events like birthdays, Mat ariki, Chinese New Year, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. The young people with a disability (YPDs) enjoy the van outings, technology-based activities, music sessions and one on one discussions.</p> <p>The family/resident completes a Map of Life (MOL) on admission, which includes previous hobbies, community links, family, and interests. A completed copy of the MOL is in the resident's room for easy access to all staff. The individual activity plan is incorporated into the 'My Day My Way' care plan and is reviewed at the same time as the care plan in all resident files reviewed, at least six-monthly. All resident files reviewed had completed MOL, activities care plans and activity registers. Activity plans are evaluated at least six-monthly. Resident meetings are held monthly. Residents/family have the opportunity to provide feedback on the activity programme through resident meetings and satisfaction surveys. The residents' have weekly movie afternoons and were seen to greatly enjoy comedy television programmes.</p> <p>Residents and family members interviewed spoke positively about the activities programme and activities team.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>The files reviewed for residents who had been in the service for six months or longer demonstrated that all interRAI assessments and care plans were evaluated at least six monthly or when changes to care occurred. Evaluations are documented and identify progress to meeting goals. 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 the RN, activities staff resident/family and clinical manager. The files reviewed reflected evidence of family being involved in the planning of care and reviews and if unable to attend, they received a copy of the reviewed plans. In all the files reviewed the care plans had been read and signed by EPOA/family. There is at least a three-monthly review by a medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access	FA	<p>The service facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the resident files reviewed. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist, mental health services for older people, dietitian or other allied health professionals. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, DHB</p>

or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		specialists and allied health services as required.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets were available. Sharp's containers were available and met the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. Gloves, aprons, goggles and face shields were available for staff. A spills kit was available.</p>
<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>	FA	<p>The building has a current building systems status report issued in lieu of a building warrant of fitness (due to Covid restrictions) that expires on 23 September 2022.</p> <p>The facility has four wings comprising of two hospital units (Kowhai and Rata), a secured dementia and psychogeriatric unit (Koru) and a rest home unit (Manuka). The facility has three floors with Kowhai and Manuka being on lower ground, the main entrance and Koru on the ground floor, and Rata wing on the first floor. The service has a connecting lift that is able to take an ambulance stretcher, stairway and also a wheelchair accessible ramp between the ground and lower ground floors. Each unit has a large lounge and dining area with a number of smaller furnished alcoves serving as family/whānau rooms.</p> <p>There is a full-time maintenance manager who works from Monday to Friday who is on call afterhours and on weekends. The Bupa 52-week planned maintenance programme is implemented to address reactive and planned maintenance. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. Fire equipment is checked by an external provider. All ensuites, showers and utility areas had non-slip vinyl flooring. The facility has sufficient space for residents to mobilise using mobility aids and residents were observed moving around freely. The external area is well maintained. Residents had access to safely designed external areas that have shade. The dementia and psychogeriatric communities have lounge areas designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas and seating alcoves that provide privacy when required. There is a safe and secure outside walking and garden areas, which were safely fenced and easy for residents to access. The facility has its own van for transportation of residents to outside appointments and activities. The van had a</p>

		<p>current registration and WOF. The staff transporting residents held a current first aid certificate.</p> <p>The registered nurses and caregivers stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate toilets and showers in the rest home, hospital, dementia and psychogeriatric units. All the rest home, dementia and psychogeriatric rooms have a hand basin. On the first floor (Rata) hospital community, all rooms have a shared ensuite between two residents. In the lower ground floor (Kowhai) hospital community residents' rooms have toilet ensuites and hand basins. There are sufficient numbers of communal toilets and mobility bathrooms located close to communal areas. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Communal, visitor and staff toilets are available and contained flowing soap and paper towels. Communal toilets and bathrooms had appropriate signage and locks on the doors. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is sufficient space in each room to allow care to be provided and for the safe use of mobility equipment, shower chairs and hoists. Each unit has a large spacious lounge area that is used for activities and small groups as well as for private social interaction. There are smaller lounges for residents who prefer quiet, low stimulus areas. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The communal areas include open plan lounges and dining areas (with kitchenettes in the Rata and Koru communities) and several smaller lounges and family/whānau rooms in each wing for quiet activities such as reading or for visitors. The lounge/dining areas are large enough to cater for activities. Residents were observed to be moving freely with the use of mobility aids. Dining and lounge furniture were well arranged to facilitate this. Seating and space can be arranged to allow both individual and group activities to occur as observed on the days of the audit. The communal areas are easily and safely accessible for residents and visitors who would prefer a quieter activity or space.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The facility has a dedicated team of cleaning staff who have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Cleaning trolleys are stored in locked rooms throughout the facility when not in use. Safety data sheets were available in the laundry, kitchen, sluice rooms and chemical storage rooms.</p> <p>All laundry is undertaken on site by dedicated laundry staff providing a seven day per week service. The laundry is spacious and well organised and divided into a 'dirty and clean' area. Laundry staff member interviewed described appropriate systems for managing infectious laundry. All chemicals were stored in a locked cupboard. There were adequate linen supplies sighted in the facility linen-store cupboards.</p> <p>There are sluice rooms in each part of the facility for the disposal of soiled water or waste. The chemical provider audits the effectiveness of chemicals for laundry and cleaning services. Residents and family members interviewed were satisfied with the standards of cleanliness and in the facility and the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. There is a first aid trained staff member on every shift and on outings. The facility has an approved fire evacuation plan and fire drills occur six-monthly. Smoke alarms, sprinkler system and exit signs were in place. The service has alternative gas facilities for cooking in an event of a power failure with a backup system for emergency lighting and battery backup. Oxygen cylinders are available. There is a civil defence kit in the facility and stored water. Call bells are evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is secured at night and a security firm provides two checks each night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated with thermostatically controlled ceiling and panel heater. Resident bedrooms and communal areas are well ventilated and have adequate lighting. Documentation and visual inspection evidenced that the environment is maintained at a safe and comfortable temperature. There is a dedicated smoking area for residents. All rooms have external windows that open, allowing plenty of natural sunlight. The residents and family members interviewed confirmed temperatures in the communal areas and bedrooms were comfortable.</p>
<p>Standard 3.1: Infection control management</p>	FA	<p>Bupa Glenburn has an established infection control (IC) programme that is being implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and</p>

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		<p>has been linked into the incident reporting system. A unit coordinator is the designated infection control coordinator with support from the registered nurses and the clinical manager. There is a job description for the infection control (IC) coordinator and clearly defined guidelines. The infection control programme is linked into the quality management programme. The infection control (IC) committee meets monthly, and minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents and all staff working in care have received both doses and a booster of the Pfizer Covid-19 vaccine. Residents and staff are offered the influenza vaccine. Covid-19 scanning/manual sign in is mandatory on entry to the facility and the use of face masks is required as part of Covid-19 red traffic light level restrictions. Covid-19 education has been provided for all staff, including hand hygiene and use of PPE. Bupa has monthly infection control teleconferences for information, education and discussion and COVID updates should matters arise in between scheduled meeting times.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Bupa Glenburn. The infection control committee meet monthly and then feed into staff, clinical and quality meetings. The IC coordinator has completed training in infection control. External resources and support are available through the Bupa quality & risk team, external specialists, microbiologist, GP, wound nurse specialist and DHB when required.</p> <p>Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. Policies include information and a response framework on Covid 19 preparedness and extend to cleaning and laundry practices including cleaning and disinfecting of surfaces. Policies are updated regularly and directed from head office.</p>

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff. Staff have completed competencies for handwashing and the correct use of PPE. Scheduled training related to the facility's Covid-19 preparedness occurs, and the facility receives regular updates regarding the Covid-19 alert/traffic light level changes from Bupa's infection control specialist.</p> <p>The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice, education packages and group benchmarking.</p> <p>Consumer education is expected to occur as part of the daily care.</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 coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Short-term care plans are used. Surveillance data including trends, analysis and corrective actions/quality are discussed at staff and clinical meetings. Corrective actions are established where trends are identified and if there is an emergent issue, it is acted upon in a timely manner.</p> <p>Covid screening is done prior to entry to the facility for all new residents. There has been one suspected outbreak (respiratory) affecting five residents in 2021 which was appropriately managed and included liaison with the local DHB. Public health authorities were notified as a precaution, however all residents tested negative for Covid-19</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	FA	<p>There is a regional restraint group at an organisation level that reviews restraint practices. The Glenburn quality committee is also responsible for restraint review and use. There is a documented definition of restraint and enablers. There are clear guidelines in the policy to determine what is restraint and what is an enabler. The restraint policy includes comprehensive restraint procedures.</p> <p>At the time of the audit, there was one resident with a lap belt as an enabler and 18 hospital and PG</p>

minimised.		<p>residents using restraint. The hospital resident using a lap belt as an enabler did not have interventions documented in the care plan (link 1.3.5.2).</p> <p>Staff begin their training on restraint minimisation during their orientation. This training continues annually and includes competency assessments.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint coordinator position was vacant at the time of the audit and was being filled by the general manager and clinical manager. Plans are in place to appoint a unit manager to this role. Assessment and approval processes for restraint interventions include the clinical manager, registered nurses, resident or family representative and GP or NP. Restraint review is part of the quality team meeting. Types of approved restraints include lap belts, bedrails, and handholding.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Suitably qualified and skilled staff, in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff.</p> <p>A comprehensive assessment for residents who require restraint is being implemented. However, links to the residents' care plans were missing in two of the three residents' files reviewed where restraint was in use (link 1.3.5.2).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has a restraint and enablers register. At the time of the audit 12 hospital level residents were using restraint with one resident using two restraints (three t-belts, eight bedrails, and one hand holding). Six PG residents were using restraints: bedrails (two), t-belts (one) and handholding (three). The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are followed. Monitoring forms are in place for when the restraint is in use, however, consistent evidence of monitoring charts being completed were missing in all three of the resident files reviewed where restraint was being used overnight (link 1.3.6.1).</p>

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation is comprehensively documented. Evaluations are scheduled two-three-monthly as part of the ongoing reassessment for the residents on the restraint register and as part of their care plan review. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint usage throughout the organisation is also monitored regularly and is benchmarked. Review of this use across the group is discussed at the six-monthly regional restraint approval group teleconference meeting and information is disseminated throughout the organisation.

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)
Criterion 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	An electronic complaints register is in place although four of ten complaints reviewed in 2021 did not include what actions were taken. All four complaints were documented as resolved. In addition, two complaints documented in the quality meeting minutes (30 December 2021) in relation to response to call bells and communication did not indicate that they had been lodged in the complaints register.	The electronic complaints register was missing evidence of all dates and actions taken in four of ten complaints reviewed. Two complaints documented in the quality meeting minutes (December 2021) were not documented as lodged in the electronic complaints register.	Ensure the complaints register includes all complaints, dates and actions taken. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring	PA Moderate	Evidence of a corrective action plan was missing for a selection of areas where improvements were identified.	i) Corrective plans were not developed following the 2021 resident/family survey where a reduction in satisfaction levels were evidenced.	Ensure corrective action plans are developed, implemented

improvement in order to meet the specified Standard or requirements is developed and implemented.			<p>ii) Corrective action plans were either missing evidence of completion or sign off for two call bell audits that took place in 2021.</p> <p>iii) Corrective action plans were missing for trends identified in the quality meeting around complaints received in 2021.</p>	<p>and signed off where opportunities for improvements are identified.</p> <p>90 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Moderate	The service has a comprehensive policy detailed the assessments required upon admission and the timescales involved; however, this policy was not followed in all of the files reviewed.	One long term rest home, and one short-term respite rest home level resident did not have the clinical and risk assessments required by policy completed despite being in the service for more than a week. This included a lack of behavioural assessment for a resident displaying behaviours that challenge.	<p>Ensure clinical and risk assessments are completed for all residents within the timeframes detailed in policy.</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 outcomes identified by the ongoing</p>	PA Moderate	The RNs complete assessments to identify the care needs of the resident and use this information to inform the development of the care plan. Not all care plan interventions for assessed care needs are documented in the long-term care plans in sufficient detail to guide the care staff. There is evidence of the use of short-term care plans, and these have signed out or added to the long-term care plan, if not resolved.	<p>One hospital resident file sampled did not contain sufficient detail to guide the care staff in the management of diabetes and falls prevention.</p> <p>One dementia level resident file sampled did not contain sufficient detail to guide the care staff in the management of diabetes.</p>	Ensure that clinical risk assessments are completed where indicated and the care plan interventions are documented in sufficient detail to guide the care

assessment process.			<p>One hospital level resident did not have the minimum millilitres of urine per 4-hour period documented to guide staff in assessing catheter blockages as required in their care plan.</p> <p>One hospital resident did not have enabler use, and two hospital level residents did not have restraint use documented in their care plans.</p>	<p>staff.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Interviews with the clinical manager and registered nurses demonstrated an understanding of the assessment, monitoring and management plans. Monitoring forms are used to monitor residents' health and well-being including blood pressure and pulse, weight, blood sugar levels, behaviour, repositioning, food and fluid intake/output. These were not always consistently completed for residents at high risk of pressure injury or with restraint. Short-term care plans sighted on the day of audit included wounds, skin tears and infections. These had been reviewed regularly and signed off when resolved or transferred to the long-term care plan.</p>	<p>One hospital resident did not have the required repositioning consistently documented as per their care plan.</p> <p>One hospital resident did not have positioning angles followed and maximum seating times adhered to as documented by the wound specialist nurse.</p> <p>Three hospital residents did not have their restraints consistently monitored as per policy requirements.</p>	<p>Ensure resident monitoring charts are consistently and comprehensively completed as per policy and residents positioned as detailed in their care plan.</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.