

Bupa Care Services NZ Limited - Fergusson Rest Home & Hospital

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Fergusson Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 15 October 2018 End date: 16 October 2018
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:	105

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
Yellow	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
Red	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

Bupa Fergusson provides hospital (geriatric and medical), rest home and dementia level care for up to 112 residents. On the day of audit there were 105 residents.

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

The service is managed by a care home manager who is a registered nurse (RN). The care home manager has been in the role since February 2018 and has been at Bupa for 10 years. She is currently supported by an acting clinical manager (unit coordinator) who starts in the clinical manager role a fortnight after the audit.

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

Three of the three shortfalls identified as part of the previous audit continue to be areas requiring improvement. These are around care plan interventions, wound care documentation and medication management.

This audit also identified further areas requiring improvement around timeliness of care plans, evaluation of care plans, complaint management, full implementation of the quality system, and training for staff.

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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Information about services provided is readily available to residents and families/whānau. Discussions with families identified that they are fully informed of changes in their family member's health status. The care home manager has an open-door policy. Complaints processes are documented, and residents and families are aware 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 low risk.
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Services are planned and coordinated and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for the day-to-day operations of the facility. An annual resident/relative satisfaction survey is completed. Quality and risk processes are documented for the service to follow. There are human resource policies including recruitment, selection, orientation and staff training and development. An orientation programme is in place for new staff. There is an annual in-service training calendar schedule. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

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 utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration. Resident files include three monthly reviews by a general practitioner. There is evidence of other allied health professional input into resident care.

All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed include documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner/nurse practitioner.

An activities programme is implemented separately for the rest home, hospital and residents in the dementia unit. The programme includes community visitors and outings, entertainment and activities that meets the recreational preferences and abilities of the residents.

All food and baking is done on-site. All residents' nutritional needs are identified and documented. Choices are available and are provided. The organisational dietitian reviews the Bupa menu plans. Nutritious snacks are available 24/7 in the dementia unit.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place.

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.
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The service has restraint minimisation and safe practice policies and procedures in place. At the time of audit there were six residents requiring the use of restraints and six residents using enablers. Staff receive training around restraint minimisation and the management of challenging behaviour.

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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	9	0	4	4	0	0
Criteria	0	35	0	4	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
<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 complaints procedure is provided to resident/relatives at entry and also around the facility. Discussion with residents and relatives confirmed they are provided with information on the complaint process. The care home manager has overall responsibility for managing the complaints process at Fergusson. There have been two documented complaints received in 2018 year to date, these have been actioned and documentation reflects follow up. However, there was no documented records available to evidence management of 2017 complaints. The manager (new in 2018) could not locate any records of 2017 complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Twelve accident/incident forms reviewed for September 2018 identified family were kept informed. Three family members (one hospital, one rest home and one dementia care) interviewed stated that they are kept informed when their family member's health status changes. Resident/relative meetings are held every three months. Six residents (three hospital and three rest home) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. An introduction to the dementia care unit booklet provides information for family, friends and visitors visiting the facility. An interpreter policy and contact details of interpreters is available. Interpreter</p>

conducive to effective communication.		services are used where indicated
<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>Bupa Fergusson provides hospital (geriatric and medical), rest home and dementia level care for up to 112 residents. On the day of audit there were 105 residents, 48 rest home residents including one resident on a palliative care contract, 42 hospital residents including one resident on respite care and one resident on a younger person with disabilities (YPD) contract, and 15 residents in the secure dementia unit. There are 10 dual-purpose beds in the rest home wing.</p> <p>A vision, mission statement and objectives are in place. Annual goals for the facility have been determined, which link to the overarching Bupa strategic plan. Fergusson is part of the Central Bupa region and the managers from this region meet bi-monthly to review and discuss the organisational goals and their progress towards these. The operations manager teleconferences monthly and completes a report to the director of care homes and rehabilitation. A quarterly report is prepared by the care home manager and sent to the Bupa continuous service improvements (CSI) team on the progress and actions that have been taken to achieve the Fergusson quality goals.</p> <p>The service is managed by a care home manager who is a registered nurse (RN). The care home manager has been in the role since February 2018 and has been at Bupa for 10 years. She is currently supported by an acting clinical manager (unit coordinator) who starts in the clinical manager role a fortnight after the audit. The acting clinical manager has worked at Fergusson for three years. The care home manager and acting clinical manager are supported by a Bupa regional manager and three-unit coordinators.</p> <p>The care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service.</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</p>	PA Low	<p>Bupa has a robust quality system and process. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. An annual internal audit and meeting schedule was sighted for the service, however not all internal audits and quality, staff, and clinical/RN meetings for 2018 have been completed as per the schedule. Not all required corrective action plans were completed or signed off. Riskman has been implemented by Bupa which is an electronic data collecting system. All incidents, infections and falls are completed on the online system. Quality data information is discussed, at the staff, quality and clinical/RN meetings (eg, complaints, infection control and incident/accidents) and the results are posted in the staffroom. However not all quality, staff and clinical/RN meetings have been completed as per the meeting schedule. Corrective actions required have not been completed or signed off.</p> <p>An annual satisfaction survey is completed, and the June 2017 results demonstrated an 85% positive outcome. Corrective actions were established in areas identified as below the national average (ie, around food services). The health and safety programme includes specific and measurable health and safety goals that are regularly</p>

<p>principles.</p>		<p>reviewed. There is a health and safety officer (care home manager) who is supported by health and safety representatives. The health and safety team meet monthly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. The hazard register is reviewed annually last occurring on 16 March 2018. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.</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>	<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. All incidents are coded in severity on Riskman (severity 1-4) with 4 being the most severe. All resident incidents logged with a severity of 3 or 4 are automatically escalated to the Bupa CSI team immediately and the regional operations manager. Actions are then followed up and managed.</p> <p>Twelve accident/incident forms were reviewed across the three service areas (five hospital, four rest home and three dementia). Incident forms reviewed reflected a clinical assessment, follow-up by a RN and identified ongoing assessment and evaluation by an RN post-incident. Neurological observations were completed for eight resident unwitnessed falls or those falls that resulted in a potential head injury. The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 notification made since the last audit. One stage three pressure injury in October 2018 and a gastro outbreak in October 2017 was notified to the public health authorities.</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>PA Low</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one unit coordinator, two RNs, three caregivers and one kitchen manager) included evidence of the recruitment process including police vetting, signed employment contracts, job descriptions and orientation checklists. Missing, was evidence of completed annual performance appraisals. A register of registered nursing staff and other health practitioner practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation is on files and staff described the orientation programme.</p> <p>There is an annual in-service training calendar schedule, however there was no documented evidence of eight hours annual training being completed in the last year. Discussion with the caregivers confirmed that monthly in-service training was not consistently completed in the last 12 months. Nine caregivers are employed to work in the dementia care unit with six having completed their national dementia qualification. Three caregivers are in the process of completing their qualification and have all commenced work within the last 18 months. Twelve RNs are employed and five have completed their interRAI training. Core competencies are completed annually, and a</p>

		record of completion is maintained (signed competency questionnaires sighted in reviewed files).
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. There is a full-time care home manager and acting clinical manager who work from Monday to Friday. The acting clinical manager oversees and provides support for the unit coordinators (the acting clinical manager is also the unit coordinator(UC) in the hospital. The service was currently recruiting for the UC role in the hospital). An enrolled nurse (EN) is the unit coordinator in the rest home and there is a RN unit coordinator in the dementia unit. The unit coordinators work from Monday to Friday. There is also a RN in the hospital across all shifts 24/7. RNs are supported by sufficient numbers of caregivers across all shifts. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents, and staffing can be adjusted related to the needs of the residents. There is a pool of casual staff to cover leave and sickness. Separate laundry and cleaning staff are employed seven days a week.</p> <p>The facility is divided into three units.</p> <p>In the hospital unit there are 38 hospital residents and two rest home residents. There is a unit coordinator/RN who is supported by a RN on duty on the morning and afternoon shifts, and one on the night shift. There are nine caregivers on duty in the morning shift (four long and five short shifts), six on the afternoon shift (four long and two short shifts) and two caregivers on the night shift.</p> <p>In the rest home unit, there are 46 rest home residents and four hospital residents. There is unit coordinator/RN who is supported by a RN on duty in the morning shift. There are six caregivers on duty in the morning shift (four long and two short shifts), four on the afternoon shift (two long and two short shifts) and one caregiver on the night shift.</p> <p>In the dementia care unit, there are 15 dementia residents. There is unit coordinator/EN who is supported by a RN on duty in the morning shift. There are three caregivers on duty in the morning shift (two long and one short shift), three on the afternoon shift (one long and two short shifts) and one caregiver on the night shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	PA Moderate	<p>The medication management policies and procedures comply with medication legislation and guidelines. Resident's medicines are stored securely in the medication room/cupboards. Weekly checks of the controlled medication were not always documented, and eye drops not dated, with some dated eye drops opened longer than the specified times.</p> <p>Medication administration practice complied with the medication management policy for the medication round sighted. This is an improvement from the previous audit. There was documented evidence of three monthly reviews by the GP. Registered nurses and caregivers administer medicines. All staff that administer medicines are deemed as competent and have received medication management training. All medications were evidenced to be</p>

requirements and safe practice guidelines.		administered as prescribed on the electronic medication system, this is an improvement from the previous audit. Temperature monitoring of the medication fridges was not always completed daily as per Bupa policy. There were no residents self-administering medication on the day of audit. There are no standing orders.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a dedicated kitchen manager who oversees food management. The food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and there is a national menu in place that has been audited and approved by an external dietitian. There are policies in place to guide staff. All food is cooked on-site in a large commercial kitchen. There is sufficient storage available. Stock rotation is practised. Hot food temperatures are monitored daily on all meals (records sighted). Fridges and freezers have temperatures monitored daily. Chilled inward goods are temperature checked on delivery and prior to storage. Daily air temperatures are recorded. Resident likes, and dislikes are known and recorded in the kitchen, and alternatives are offered. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes and is reviewed six monthly, as part of the care plan review. Special diets (ie, soft and pureed diets) are noted on the kitchen noticeboard, which can be viewed only by kitchen staff. Meals are served from bain maries to the residents in the dining rooms and can be delivered to rooms as required. Specialist utensils and plates are available for residents. The resident annual satisfaction survey monitors food satisfaction. The kitchen is included in the internal audit programme. Staff have been trained in safe food handling and chemical safety. Residents and relatives interviewed commented positively on the meals provided.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Care plans reviewed demonstrate service integration and input from allied health. All resident care plans sampled were resident centred; however, not all support needs were documented in sufficient detail. Family members interviewed, confirmed care delivery and support by staff is consistent with their expectations. One hospital resident had a specific 'End of Life' care plan in place following a change in health status. Other specific care plans were implemented for specific health needs, including (but not limited to) dementia, medical needs, diabetes, and chronic wounds. The contracted physiotherapist has completed transfer plans. Short-term care plans were in use for changes in health status and signed-off as resolved or transferred to the long-term care plan.
Standard 1.3.6:	PA	Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at

<p>Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>Moderate</p>	<p>handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>On the day of audit, it was not clear how many wounds were being treated and the wound logs were not up to date. Wound assessment, monitoring and wound management plans continue to be an area requiring improvement. There were six pressure injuries including three facility acquired (one stage three and two without a grade), and three non-facility acquired (one stage one and two stage two).</p> <p>Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts sighted included behaviour charts, restraint monitoring forms, turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</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>	<p>FA</p>	<p>The activity team at Bupa Fergusson continues to comprise of one activity coordinator and three activity assistants who deliver the activity programme over seven days per week.</p> <p>The two activity assistants who work in the dementia unit have completed NZQA level 4 dementia modules. The activity team have access to the Bupa diversional therapy (DT) team at head office and attend the regional DT/activities regional study days with training and education including guest speakers.</p> <p>Each resident has an individual activities programme, which is reviewed when their plan of care is reviewed and as part of their interRAI assessments.</p> <p>The group activity programme is implemented over seven days per week in all three areas. There is a large open plan central lounge/dining area which is used for activities for rest home and hospital residents. There are separate rest home/hospital and dementia programmes with activities that meet the needs and preferences of the resident groups; however, some activities are integrated such as entertainment, as observed on the day of audit. Variations to the group programme are made known to the residents. Residents may choose to participate in any group programme. Individual programmes are delivered to residents in their rooms when they are unable to or choose not to participate in the group programme.</p> <p>The group programme covers physical, cognitive, social and spiritual needs. There are regular visiting entertainers and community groups. Targeted group programmes are offered as appropriate to meet the needs of subsets of residents. There is a weekly Catholic church service and other denominations and some residents attend church services in the community. Residents can go on outings using the service's van. Some rest home residents choose to use alternative transport arrangements to attend community interests. A caregiver accompanies the activity person on outings. There is a designated van driver.</p>

		<p>Residents have the opportunity to provide feedback on the activity programme through the bi-monthly resident meeting and resident satisfaction surveys.</p> <p>Residents and relatives interviewed were satisfied with the activities programmes on offer.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>Multidisciplinary reviews are documented in file that involve the RN, GP, activities staff, physiotherapist (if involved) and resident/family. The family are notified of the outcome of the review by phone call and if unable to attend, they receive a copy of the reviewed plans. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p> <p>Not all care plans documented a six-monthly evaluation against stated goals and STCP were not always evaluated.</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 holds a current warrant of fitness and the facility employs a full-time maintenance manager. There are proactive and reactive maintenance management plans in place. The grounds and gardens are maintained by a qualified gardener who assists with maintenance. Medical equipment requiring servicing and calibration, and testing and tagging is up to date. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors to the facility. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents are designated drivers.</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 officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners and local laboratory that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Effective monitoring is the responsibility of the infection control officer. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff.</p> <p>Infections statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark.</p>

		All infections are documented monthly in an infection control register.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the caregiver and nursing staff confirmed their understanding of restraints and enablers. Enablers are assessed as required, for maintaining safety and independence and are used voluntarily by the residents. There are six residents with seven restraints (six T belts and one bed rail) and six residents using seven enablers (four bed rails and three chair briefs). An assessment for restraint/enabler use and consent form were evidenced completed in the two restraint and three enabler resident files reviewed. However, the care plans reviewed did not have documented evidence of appropriate interventions and risks involved (link 1.3.5.2).

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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>There is a complaints procedure to guide practice. There have been two documented complaints received in 2018 year to date, however there was no documented records available to evidence management of 2017 complaints. The manager (new in 2018) could not locate any records of 2017 complaints.</p>	<p>There were 27 complaints documented in the quality meeting minutes from March to September 2017 (there were no quality meetings held in January, February, October, November and December 2017, so there were no complaint numbers available for those months). The manager could not locate a complaint register or documentation related to those complaints.</p>	<p>Ensure that there are copied of all complaints on the complaint register and documentation is maintained to reflect response letters and communication to the complainant.</p>

				90 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Bupa has a robust quality system and process. An annual internal audit and meeting schedule was sighted for the service, however not all internal audits and quality, staff, and clinical/RN meetings have been completed as per the schedule. There had been only one quality, three RN/clinical and three staff meetings in 2018 (scheduled as bi-monthly). In 2017 there had been 7 of 12 quality, 4 of 12 staff and 4 of 12 RN/clinical meetings completed in 2017 (these were all scheduled as monthly)</p>	<p>i) Not all quality, staff and RN/clinical meetings have taken place according to the meeting schedule. There has been only one quality meeting, three RN/clinical meetings and three staff meetings in 2018 (scheduled as bi-monthly). In 2017 there had been 7 of 12 quality, 4 of 12 staff meetings and 4 of 12 RN/clinical meetings completed in 2017 (these were all scheduled as monthly). Corrective actions identified in meeting minutes that required actioning have not been completed or signed off.</p> <p>ii) The internal audit schedule has not always been adhered to. Twenty of thirty-eight internal audits for 2018 have not been completed. Not all corrective action plans required from shortfalls identified in internal audits had been signed off as completed.</p>	<p>i) Ensure that facility meetings take place according to the meeting schedule and corrective actions required are completed and signed off.</p> <p>ii) Ensure that the internal audit schedule is adhered to and that all required corrective action plans are completed and signed off.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective</p>	PA Low	<p>There is an annual in-service training calendar schedule, however not all scheduled training has been completed the last two years. Discussion with the caregivers confirmed that monthly in-service training was not consistently completed in the last 12 months. Performance appraisals were not all up to date in files reviewed.</p>	<p>In-service training hadn't been completed for the following topics in the last two years; complaints/open disclosure, communication, end of life/death, challenging behaviour, nutrition/hydration, pain management, incontinence management, sexuality/intimacy and spirituality/counselling.</p> <p>Seven staff files were reviewed, three of the seven files did not have documented evidence of an up-to-date annual performance appraisal completed.</p>	<p>Ensure that sufficient staff attend education sessions to provide certainty that staff have received training in</p>

services to consumers.				<p>required areas.</p> <p>Ensure annual performance appraisals are up to date</p> <p>90 days</p>
<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>	<p>PA</p> <p>Moderate</p>	<p>The services medication management policy outlines the policies and practices to be followed in relation to medication management. Staff interviewed who administer medication, could describe safe medication management and administration practices. All medication was evidenced to have been given as prescribed for all residents on the electronic medication chart. Medication fridge temperatures had not been consistently recorded in the hospital. This is a continued shortfall from the previous audit. Eye drops were not always dated, and some eye-drops opened longer than the specified timeframe. Weekly controlled medication checks were not always documented.</p>	<p>i) Temperature recordings for the medication fridge in hospital were not evidenced to be recorded daily.</p> <p>ii) Three eye drops were not dated on opening in the rest home and two eye drops were opened longer than the set time in the rest home.</p> <p>iii) The controlled medication book was not checked weekly in the rest home.</p>	<p>i) Ensure fridge temperature monitoring is conducted as per policy.</p> <p>ii) Ensure eye drops are dated on opening and are not stored longer than the set time once opened.</p> <p>iii) Ensure the controlled medication is checked weekly.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment,</p>	<p>PA</p> <p>Moderate</p>	<p>All resident files reviewed included a current care plan and assessments. The service has a plan in place to ensure timeliness of new assessments, long-term care plans and evaluations. Not all care plan interRAI,</p>	<p>(i)One rest home and two dementia care files reviewed did not have the initial interRAI and long-term care plan completed within required timeframes following admission.</p>	<p>(i)-(ii) Ensure that interRAI's, care plans and evaluations are documented</p>

planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.		assessments and evaluations have been timely.	(ii) one hospital and one rest home file reviewed did not have six-monthly care plan evaluations completed within 6 months.	within set timeframes. 60 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Care plans were developed by the registered nurses and were based on information gathered through the assessment process. Not all care plans reviewed documented all the care interventions required, this is a continued shortfall from the previous audit.	Two of three hospital level care and one of two rest home plans reviewed did not include all interventions needed. (i) one hospital file did not include interventions for care and prevention of pressure injuries. Also, the long-term care plan and a short-term care plan included interventions which were no longer applicable. (ii) one hospital file stated the resident was low falls risk, but the resident had sustained eight falls since January and two falls in September. (iii) The rest home level care plan was unclear regarding intervention around falls prevention. There was also contradicting information regarding mobilisation. (iv) The care plans reviewed for two restraint and three enabler resident files did not have documented evidence of interventions or risks.	(i)-(iv) Ensure care plans have clear interventions documented for all assessed care needs. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs,	PA Moderate	Wound assessment, monitoring and wound management plans are in place for wounds. Staff were aware who had wounds and interventions, however wound care documentation was not clear.	i) Each of the units (hospital, rest home and dementia unit) had wound files and wound logs, however the logs did not match the current wounds being managed. ii) Two of the facility-acquired pressure injuries (both rest home) were not graded. iii) It was not clear in the wound documentation reviewed, which evaluation belonged to which	i) Ensure that the wound log is up to date. ii) Ensure that pressure injuries are graded. iii) Ensure that wound plans

and desired outcomes.			<p>wound.</p> <p>iv) Two hospital level wound plans had more than one wound documented per form.</p> <p>v) The service has a process where healed wounds continue to be monitored for a period post-healing and remain in the wound log, however it was not always clear if the wound was healed and monitored or continuing to require treatment.</p>	<p>and evaluations are clearly labelled and linked to each other.</p> <p>iv) Ensure there is one wound per form.</p> <p>v) Ensure that the wound plan is clear regarding the treatment (monitoring and care interventions).</p> <p>90 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	<p>The service documents short-term care plans for acute and short-term needs, but these are not always evaluated and/or closed off as needed. There is a process in place for evaluating long-term care plans and multidisciplinary reviews, but the evaluations did not always document progress towards goals.</p>	<p>i) One hospital and one dementia activity plan did not document evaluation of activities towards goals with 'no change' the only comment. Care plans for weight management for a rest home resident and the transfer plans for two hospital level residents had not been evaluated to document any progress towards goals.</p> <p>ii) Short-term care plans were not evaluated for one hospital and one rest home resident.</p>	<p>i) Ensure that care plans evaluate progress towards stated goals.</p> <p>ii) Ensure that the short-term care plans are evaluated or closed as needed.</p> <p>90 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.