Bupa Care Services NZ Limited - Windsor Park Specialist Senior Care Centre

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:	Windsor Park Specialist Senior Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 13 November 2019 End date: 14 November 2019

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: 58

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

Windsor Park Care Home is part of the Bupa group. The service is certified to provide rest home, hospital (medical and geriatric), dementia and residential disability (physical) level of care for up to 79 residents. On the day of audit there were 58 residents.

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

The care home manager is a registered nurse and has been in the role since January 2019. The clinical manager (RN) has been in the role for 18 months and has a background in aged care. They are supported by a recently appointed unit coordinator, registered nurses and long-standing caregivers.

This surveillance audit identified that improvements are required around meetings, aspects of health and safety, orientation and appraisals, and infection control surveillance.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Relatives interviewed stated they felt well informed. Incident reports evidenced relative notification of adverse events. A complaints register is maintained. Complaints have been well documented and managed.

Organisational management

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

Bupa Windsor Park has a current business plan and quality assurance and risk management plan that outlines objectives for the year. Aspects of quality information are reported to the monthly quality committee meetings. Internal audits are being conducted according to the schedule. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly resident meetings and via resident/relative satisfaction surveys. Incidents are collated monthly and opportunities to minimise risks are identified. An employment process is in place. The in-service education programme for 2019 is being implemented. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

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

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses and senior medication competent caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Residents commented positively on the meals. Snacks are available at all times.

Safe and appropriate environment

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

The building has a current warrant of fitness. Preventative and reactive maintenance occurs. All communal areas are accessible for residents using mobility aids. External areas are well maintained and provide seating and shade. There is a secure external area in the dementia unit with paths with no dead ends.

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.

Bupa Windsor Park has restraint minimisation and safe practice policies and procedures in place. At the time of the audit there were four residents with restraints and two residents using an enabler. Assessments were fully completed. There is a designated restraint coordinator. Staff receive training around restraint minimisation.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

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 is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. There has been one Norovirus outbreak in 2019.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	2	1	0	0
Criteria	0	37	0	3	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Complaint forms are available in the foyer. Staff are aware of the complaints process and to whom they should direct complaints. A complaint register is maintained on the Riskman electronic system. There have been three complaints registered since the previous audit. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed have been followed up and implemented. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policy, alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms on Riskman (the electronic data collection software), have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten incident forms were reviewed for October and November 2019 and all identified that family had been informed. Four relatives (three dementia and one hospital) interviewed stated that they are kept informed when their family member's health status changes. Residents interviewed (three rest home and four hospital) stated communication was good.

conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Bupa Windsor Park is certified to provide rest home, hospital (geriatric and medical), dementia and residential disability (physical) level care for up to 79 residents. On the day of audit there were 58 residents. There are 29 dedicated rest home beds with 24 rest home level residents including one resident on respite; 34 hospital beds with 20 residents including a resident on a YPD contract, and one resident on an ACC contract. The dementia unit as 16 beds with 14 residents on the day including one resident on respite. 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. Windsor Park is part of the Southern Bupa region, and the managers from this region meet bi-monthly to review and discuss the organisational goals and their progress towards these. The care home manager reports to the operations manager (southern) on a weekly basis while settling into the role, with the view to move to reporting on a monthly basis. Windsor Park has set a number of quality goals that link to the Bupa quality and health and safety goals. A quarterly report is prepared by the operations manager (on behalf of 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 Windsor Park quality goals. Quality goals include (but are not limited to); (i) decrease falls across all communities by 10%, and for 10% of staff to have PDRP. The goals have been reviewed three monthly as documented in the quality meetings since May (link 1.2.3.6). The care home manager has been in the role since January 2019, she is an experienced registered nurse (RN), who has an extensive background in teaching nurse students. She is supported by a clinical manager (RN) who has been in the role for 18 months and has a background in aged care and a recently employed unit coordinator/RN.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement	PA Low	Bupa has a comprehensive quality and risk programme documented for all Bupa services to implement. Records reviewed identified an implemented monthly monitoring of quality and risk data since mid-2019 including (but is not limited to): residents' falls; infection rates; and restraint use. However, there was no evidence of previous quality data stats. Quality and risk data, including trends in data and benchmarked results are not documented as discussed in the quality and staff meetings. Meetings have been held, but not according to the schedule, therefore information is not evidenced as discussed with staff (confirmed during staff interviews). The Bupa annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are developed when shortfalls are identified and signed off when completed. Health and safety goals have been established for 2019. A health and safety committee has been formed to include a representative from all departments. Meetings have been held (not according to schedule), and there was evidence that new and ongoing hazards are discussed. All new hazards identified have a corrective action plan in

principles.		place which has been signed off once completed. The committee looks closely at staff injuries and ensures all documentation has been completed before the end of the shift. A hazard register is in place, but there was no evidence of when this was last reviewed. Staff have not been provided with health and safety training as planned. All new staff and contractors undergo a health and safety orientation programme. There was an annual resident/relative satisfaction survey completed in 2019 that showed an overall satisfaction rate for both surveys. Corrective actions were developed, and new initiatives have been developed on food services including introducing summer salad platters, and a hot option, and changing the breakfast routines. Improvements around activities included the provision of a mobile activities trolley and setting up an education and support group for relatives from the Charlton (dementia) unit. An overall review of the activities calendar was made, and provision was also made for toys to be available for visiting children in the café area. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Individual electronic incident/accident reports are completed for each incident/accident on the Riskman system with immediate action noted and any follow-up action required. Incident/accident data is linked to the organisation's data collection data base and is used for comparative purposes (link 1.2.3.6). A review of ten incident/accident forms identified that forms were fully completed and included follow-up by the registered nurse and reviewed by the clinical manager. NOK had been informed, and neurological observations completed for unwitnessed falls. The care home manager and clinical manager are involved in the adverse event process and the incident reports identified opportunities to minimise risks. The care home manager was able to identify situations that would be reported to statutory authorities including infectious diseases, pressure injuries, serious accidents and unexpected death. Section 31 reports are completed by head office. Section 31 notifications had been made for a recent outbreak, and two unstageable pressure injuries (one facility acquired, and one non-facility acquired).
Standard 1.2.7: Human Resource Management Human resource management processes are	PA Low	Six staff files (one clinical manager, one RN, one enrolled nurse (EN) and three caregivers) reviewed, evidenced implementation of the recruitment process, employment contracts, reference checks and job descriptions were in place, however there was no evidence of role-specific orientation for new staff and no staff had a current appraisal. A register of registered nursing staff and other health practitioner practising certificates is maintained. There is an annual education and training schedule being implemented. Opportunistic education is provided via

conducted in accordance with good employment practice and meet the requirements of legislation.		toolbox talks. Education and training for clinical staff is linked to external education provided by the DHB. There are four RNs (including the unit coordinator) and one EN who have completed interRAI training. The care home manager reported a high turnover of management since the last audit with temporary managers in place. The caregivers have been fairly stable and there has been movement in the RNs with two international RNs leaving within six months of employment. All relevant staff had completed competencies on oxygen management, restraint, manual handling, and medications. There is a first aider on each duty (RN, EN or senior caregivers) and the van driver has a current first aid certificate. All regular and casual caregivers working in the dementia unit have completed the dementia standards. There are 4 caregivers who have level 4 Careerforce qualifications, 12 caregivers have a level 3 qualification and 9 have a level 2 qualification. The service is currently orientating five new caregivers, who will achieve level 2 on completion of their orientation. All nurses have a current syringe driver competency. Ten nurses (RNs and ENs) have commenced PDRP.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The care home manager, clinical manager, and unit coordinator are available during weekdays from 8.30 am to 5 pm. The care home manager is on-call after hours for any organisational concerns and the clinical manager and unit coordinator share on-call for any clinical issues. Adequate RN cover is provided 24 hours a day, 7 days a week. Registered nurses have time available to complete interRAI assessments and care planning evaluations within contractual timeframes. Charlton dementia community (14 residents); 1x EN rostered on the morning shift (6.45 am to 3.15 pm) and either an EN or senior caregiver (level 4 medicine competent) in the afternoon (2.30 pm to 11 pm) under supervision from the RN in the hospital community. They are supported by two caregivers; 1x 6.45 am to 3.15 pm and 1x 7 am to 3 pm. The afternoon shift has two caregivers rostered; 1x 2.30 pm to 11 pm and 1x 4 pm to 8 pm. One caregiver works nightshift from 10.45 pm to 7 am. Croydon and Waimea (rest home) communities (25 beds with 23 residents); 1x EN or senior caregiver are rostered on morning and afternoon shift. They are supported by one caregiver on the morning (6.45am to 3.15pm) and afternoon (2.30pm to 10pm) shifts. The EN or senior caregiver assist residents with the morning and afternoon routines. One caregiver is rostered for the nightshift. The hospital communities - Hokonui (20 beds, 11 residents including one YPD) and Waimumu (13 dual purpose beds with 10 residents including one rest home resident and one ACC). One registered nurse is rostered across all shifts with an extra EN on twice a week to cover while the RN attends to

		the GP rounds. They are supported by four caregivers; 2x 7am to 3.30 pm and 2x 7am to 3 pm. The afternoon shift has four caregivers; 2x 3.30pm to 11pm and 2x 4pm to 9 pm. One caregiver is rostered for nightshift. From 18 November 2019, the facility will have a full complement of staff with no casual shifts.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There were no standing orders. There were no vaccines stored on site. The facility uses an electronic and medico pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. RNs, ENs and senior medication competent caregivers administer all medications. Staff attend annual education and have an annual medication competency completed. All eight RNs and two ENs are syringe driver trained by the hospice. The medication fridge and room temperature are checked weekly. Eye drops are dated once opened. Staff sign for the administration of medications on the electronic system. Twelve medication charts were reviewed. Medications are reviewed at least three monthly by the GP. There was photo ID and allergy status recorded. 'As required' medications had indications for use charted.
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	The service has a kitchen manager and two other cooks who cover Monday to Sunday. There is a kitchenhand 6 am to 2 pm and another from 2 pm to 7.30 pm. All cooks have current food safety certificates. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served in each area from hot boxes. The temperature of the food is checked before serving. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well presented. 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. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted. The four weekly menu cycle is approved by the Bupa dietitian. All resident/families interviewed were satisfied with the meals. They particularly commented on the home baking. There are snacks available at all times. The food control plan was verified on 14 September 2019.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. All care plans sampled had interventions documented to meet the needs of the resident and there is documented evidence of care plans being updated as residents' needs changed. Resident falls are reported on Riskman and written in the progress notes. Neurological observations are taken when there is a head 'knock' or for an unwitnessed fall. Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies. Wound assessment, wound management and wound evaluation forms were in place for all wounds. Wound monitoring occurs as planned. There were currently five wounds being treated. There were no wounds in the dementia unit. There is currently one pressure injury. This had been seen by the wound care nurse specialist. Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is one diversional therapist (DT) who works forty hours a week. She has assistance from volunteers on a Monday and Friday. The caregivers assist with activities in the dementia unit every morning. There is an activities trolley set up for them to use. There is no weekend cover, but the DT comes in for special events. On the day of audit residents were observed playing quoits (dementia unit), taking part in a quiz and going out in the van to go shopping. There is a weekly programme in large print on noticeboards in all areas. 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. These include exercises, bingo, news from the paper, music, quizzes and games. There is a lady's group which holds coffee mornings. There is also a men's group who go out to the RSA. Dementia unit residents often come out to the activities in the rest home and hospital if suitable. 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. There is an interdenominational church service every Sunday and Catholic communion as required. Each area has a van outing weekly. Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated. The facility recently held a 'wearable arts' event with other rest homes. There is entertainment every Friday and happy hour weekly. In the dementia unit happy hour is soft drinks and chips. The facility has one cat who wanders throughout all areas. Staff also bring in dogs and chickens. There are raised garden beds for residents to potter in if desired. There is a large fenced off garden for the dementia unit residents to

		walk around. The YPD resident has poor health and is mainly a passive participant in activities. There are strong community links. Local pre-schools and schools visit. Residents go out to the RSA, card groups, embroidery group and the movies. The Zippy coffee van visits every Wednesday and residents enjoy buying from this. Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held two monthly. The residents interviewed spoke positively about the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Except for the respite resident, all plans reviewed had been evaluated by the registered nurse six monthly or when changes to care occurred. A written evaluation is completed. Short-term care plans for short- term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP. The family members interviewed (one hospital and three dementia) confirmed that they are informed of any changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building holds a current warrant of fitness which expires 6 August 2020. There is a maintenance person who works full time five days a week. There is an assistant maintenance man who works sixteen hours a week. Both work in the village as well. There is a fulltime gardener. Contracted plumbers and electricians are available when required. Electrical equipment has been tested and tagged. The hoist and scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The communal lounges, hallways and most bedrooms are carpeted. There are four bedrooms in each wing which have vinyl. The corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have seating and shade. There is safe access to all communal areas. Caregivers interviewed stated they have adequate equipment to safely deliver care for rest home and hospital level of care residents.

Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	PA Moderate	Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected monthly. There is no documented evidence of IC statistics from January to June 2019. From June to present IC statistics have been collected, but there is no analysis of data and no reporting of trends. Infection control internal audits have been completed. Infection rates have overall been low. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. There was a Norovirus outbreak early 2019. This was well documented and reported to the appropriate authorities.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. At the time of the audit, the service had four residents using restraints (three residents using bed rails and one of these residents also using a lap belt on a wheelchair, and another resident using a lap belt as a restraint). Two residents use bedrails as an enabler. Staff training around restraint minimisation and management of challenging behaviours was last completed in July 2019.

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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Monthly data collated includes infection rates, incidents, restraint and internal audits. There is no evidence of analysis or trending of the results, and no documentation in the meetings which have been held around this.	(i) Meetings are not held according to the schedule; quality, staff meetings, health and safety and restraint. (ii) Minutes of meetings held do not discuss quality data analysis or trending around infection control, incidents/accidents, internal audit	(i)-(ii) Ensure meetings are held according to the schedule and there is evidence of analysis and trending discussed. 90 days

			results.	
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Low	The two meetings held this year evidenced there was discussion around current and ongoing hazards identified. Corrective actions are in place and signed off on completion. The health and safety plan had been discussed. However, there was no evidence of the review of the hazard register, and training had not been provided as planned.	(i). The hazard register has not been reviewed at least annually. (ii). There has been no health and safety training provided to staff.	(i).- (ii). Ensure the hazards register is reviewed at least annually, and training on health and safety is provided as per schedule. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	The six staff files reviewed had an agreement, job description and competencies that were completed on employment. Evidence of qualifications and practicing certificates were on file. The care home manager had identified there were no up-to-date appraisals completed and was awaiting packs to arrive to start completing this. There was no evidence of appraisals completed for 2018.	Five staff files were reviewed, no role-specific orientation was evident on staff files. None of the five staff files reviewed had evidence of a current appraisal.	Ensure all staff have role-specific orientation completed, and evidence appraisals as per policy. 180 days
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and	PA Moderate	There is no documented evidence of infection control (IC) statistics from January to June 2019. From June (when new IC coordinator started) IC	(i). There was no documented evidence of IC statistics from	(i)-(iii). Ensure statistics collated, evidence

reported to relevant personnel and management in a timely manner.		statistics have been collected but no analysis has taken place and trends have not been identified. Meetings are not always held as per schedule (link 1.2.3.6) and reporting of trends does not occur. The facility does not benchmark IC statistics.	January to June 2019. (ii). From June to present IC statistics have been collected, but there is no analysis of data and no reporting of trends. (iii). There was no documented evidence of benchmarking with other Bupa facilities as per policy.	analysis and reporting of trends (if any identified). Ensure benchmarking with other Bupa facilities occurs. 60 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.