

# Bupa Care Services NZ Limited - Stokeswood 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:

<b>Legal entity:</b>	Bupa Care Services NZ Limited
<b>Premises audited:</b>	Stokeswood Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 24 February 2021      End date: 25 February 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	77

# 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 Stokeswood is part of the Bupa group. The service is certified to provide rest home, hospital (geriatric and medical) and dementia care for up to 87 residents. On the day of audit there were 77 residents.

This certification audit was conducted against the Health and Disability Services Standards and the contract with the district health board. This 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.

Stokeswood is managed by a care home manager (registered nurse) who has been in the role since August 2020. She is supported by a clinical manager, unit coordinators and a Bupa operations manager. Family and residents interviewed spoke positively about the care and support provided at Bupa Stokeswood.

This audit identified that improvements are required in relation to staff orientation, performance appraisals, staffing levels, adhering to care planning timeframes, and cleaning/laundry processes.

## 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.
--	--	--

Stokeswood endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## 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.
---	--	--

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who live in the service. Implementation is supported through the Bupa quality and risk management programme that is

individualised to Stokeswood and has been embedded in practice. Quality initiatives are implemented, which provide evidence of improved services for residents.

Stokeswood is implementing the organisational quality and risk management system that supports the provision of clinical care. 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. Interviews with staff, and review of meeting minutes demonstrated a culture of quality improvements. Residents receive services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. There is an in-service training calendar in place. Registered nursing cover is provided 24 hours a day, seven days a week.

## Continuum of service delivery

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

The registered nurses are responsible for each stage of service provision. Residents' records reviewed, provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. These are then reviewed and discussed with the resident and/or family/whānau input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. All staff responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The activities coordinators implement 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 themed celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times. The organisational dietitian reviews the Bupa menu plans.

## Safe and appropriate environment

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

The building holds a current warrant of fitness. All internal and external areas are safe and well maintained. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Chemicals are stored securely throughout the facility. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. At least one first aid trained staff member is on duty at all times, including 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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. At the time of audit there were two residents using restraints and two residents using enablers. The approval process for restraint use includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. Restraint use is reviewed a minimum of three-monthly.

## 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 is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training provided by Bupa head office and external training provided by the local DHB. There is a suite of infection control policies and guidelines available electronically to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education

needs within the facility. The service engages in benchmarking with other Bupa facilities. There have been two respiratory viral outbreaks in the previous year which were appropriately managed.

## 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)
<b>Standards</b>	0	45	0	4	1	0	0
<b>Criteria</b>	0	95	0	5	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location in English and in Māori. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with twenty-two staff: eight caregivers on the AM and PM shifts (three dementia, two hospital, three rest home), four staff registered nurses (RNs) (two rest home and two hospital), three-unit coordinators (rest home, hospital, dementia), one laundry, one cook, one kitchen assistant, one cleaner, and three activities staff confirmed their understanding of the key principles of the Code and its application to their job role and responsibilities.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in nine resident files (three hospital, three rest home including two long term support–chronic health conditions (LTS-CHC) contract and three dementia care) were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and registered nurses (RNs) interviewed, confirmed verbal consent is obtained when delivering care. Discussion</p>

<p>choices and give informed consent.</p>		<p>with family members stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Nine resident files of long-term residents have signed admission agreements.</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>	<p>FA</p>	<p>Information on advocacy support services is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support services. Staff receive education and training on the role of advocacy services. One complaint received in 2020 was brought forth through the HDC Advocacy service.</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>	<p>FA</p>	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident/family meetings are held three-monthly. Quarterly newsletters are provided to residents and relatives.</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>	<p>FA</p>	<p>The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using an electronic complaint register. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC). Discussions with residents and relatives confirmed they are provided with information on complaints and complaints forms. Complaints forms are also located in a visible location at the entrance to the facility, next to a suggestions box. Four complaints were received in 2020 and nil in 2021 (year-to-date). Feedback is provided to staff in staff meetings.</p> <p>Three complaints lodged, including one with HDC and one complaint lodged with the HDC advocacy service were reviewed in detail. These three complaints included acknowledgement, a thorough investigation and corrective actions (where applicable). Registered nurse meeting minutes reflected evidence of corrective actions shared with staff (e.g., RN management of emergency and critical events). One complaint around (unsubstantiated) abuse involved a period of placing an employee on leave during the investigation. All complaints lodged have been documented as resolved.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The managers (care home manager, the clinical manager) and RNs discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the three-monthly resident/family meetings. Interviews with four residents (one rest home and three hospital) and seven relatives (five hospital and two dementia) confirmed that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.</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>Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information are gathered on admission with family involvement and are integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received regular training. One complaint received in 2020 around suspected abuse has been addressed and is resolved.</p> <p>Residents are assisted and supported to maintain as much independence as possible.</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>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. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There were three residents who identified as Māori at the time of the audit. Two files reviewed indicated that their Maori values and beliefs are identified in their care plan. One resident and his two whānau were interviewed and confirmed that the resident's needs, including his cultural needs, were being met by the service. This resident enjoys playing the guitar and receives assistance with this activity once a week.</p> <p>Māori consultation is available through the documented iwi links and local Māori ministers. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. During the audit, a selection of residents were travelling to a local marae as an activity outing.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values,</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they are</p>

<p>And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>involved in developing the resident's plan of care, which included the identification of individual values and beliefs. Regular (quarterly) newsletters are provided to residents and relatives. All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Code of conduct training is also provided through the in-service training programme. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. Registered nursing staff are available 24 hours a day, seven days a week. A general practitioner (GP) visits the facility two days a week and as needed. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. Physiotherapy services are provided four hours per week. A podiatrist is on site every six weeks. The service has links with the local community and encourages residents to remain independent. Quality data is entered electronically, and benchmarked reports are provided. Corrective action plans are developed by the service where shortfalls are identified.</p> <p>The facility has a new management team in place. The care home manager and clinical manager are experienced registered nurses who understand Bupa processes and systems. A recruitment drive has been implemented, employing more staff across all areas. Recent improvements in the care home have included room refurbishments, the purchase of additional pressure relieving mattresses, implementation of a new soft diet food programme to help improve the residents' weight management and nutritional concerns, planting a vegetable garden in the dementia wing and training two RNs to become palliative link nurses to help support the staff and caring for residents at their end of life. Hospice visits the facility once per week to provide support to staff, residents and family.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	<p>FA</p>	<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. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>not) of an accident/incident. Fifteen accident/incident forms reviewed identified that family were kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes or following an adverse event.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Bupa Stokeswood Rest Home and Hospital is a Bupa residential care facility. Stokeswood provides rest home, hospital (geriatric and medical) and dementia level care for up to 87 residents. At the time of the audit there were 77 residents: 36 rest home residents, 21 hospital residents (including two residents on a long-term support – chronic health conditions (LTS-CHC) contract) and 20 residents in the 20-bed dementia care unit.</p> <p>A vision, mission statement and objectives are in place. Annual quality/health and safety goals for the facility have been determined and are regularly reviewed by the care home manager. A quarterly report is prepared by the care home manager and provided to the Bupa head office on the progress and actions that are being taken to achieve their quality goals.</p> <p>The service is managed by a care home manager/RN. The care home manager has been in the role for six months and was previously the clinical manager at this facility. Previous to this she was a unit coordinator at this facility. She has over four years of experience with Bupa and nine years of experience in aged care. She is supported by an experienced clinical manager who has recently been appointed (2 February 2021) but was previously the clinical manager at this facility for eight years (2008-2016). The management team is supported by three-unit coordinators, a regional operations manager and a regional quality partner.</p> <p>Care home managers and clinical managers attend annual forums and regional forums six monthly. The care home manager has maintained at least eight hours annually of professional development activities related to managing a rest home/hospital.</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</p>	<p>FA</p>	<p>A clinical manager, who is employed full time, supports the care home manager and steps in when the care home manager is absent. There is a regional operations manager who visits regularly and supports both managers.</p>

<p>manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality and risk management programmes are embedded into practice. Interviews with the managers and staff reflected their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule.</p> <p>Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed. RiskMan is implemented by Bupa, which is an electronic data collecting system. All incidents, complaints, infections, pressure injuries, falls, and category one incidents are completed on the online system. Interviews with staff and review of meeting minutes demonstrated an understanding of quality improvements. Quality and risk data is shared with staff via meetings and posting results in the staffroom. An annual satisfaction survey is completed, and the 2020 results demonstrated 92% of residents would recommend the home to others. Corrective actions are established in areas identified as needing improvements. These corrective actions (and the survey results) are posted for families and visitors to access.</p> <p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. There are three health and safety representatives. The health and safety team meet bi-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 regularly.</p> <p>Strategies are implemented to reduce the number of falls. This includes, (but is not limited to), a falls committee that regularly meets to review all falls, ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or</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. All</p>

<p>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>resident incidents logged with a high severity are escalated to the Bupa head office immediately and the regional operations manager.</p> <p>Fifteen accident/incident forms were reviewed across the three service levels (three skin tears, one bruise, eight unwitnessed falls, three witnessed falls). Each event involving a resident reflected a clinical assessment and follow-up by a RN. Unwitnessed falls include neurological observations until such time that the resident is considered stable.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. Section 31 notifications made since the last audit include two influenza outbreaks, and four missing residents. Public health authorities are also notified during any suspected outbreak.</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 Moderate</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Ten staff files reviewed (one unit coordinator, three RNs, four caregivers, one cook/kitchen assistant, one activities assistant) evidenced implementation of the recruitment process, and employment contracts.</p> <p>A register of practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type and includes documented competencies. New staff are buddied with more experienced staff. Missing was evidence in a selection of the files audited of staff having completed their orientation programme.</p> <p>There is an annual education and training schedule in place that addresses all required areas. In-services are regularly offered more than once per year. Staff files reviewed indicated that they have achieved a minimum of eight hours annually of education. Of the sixteen RNs at Stokeswood, seven have completed interRAI training. There are fifteen caregivers that work in the dementia unit and ten have completed the required dementia standards. The remaining five caregivers are in the process of completing their dementia standards and have been employed less than eighteen months.</p> <p>A competency programme is in place with different requirements according to work type (e.g., support work, registered nurse, and cleaner). Core competencies are completed annually, and a record of completion is maintained. RN competencies include assessment tools, BSLs/insulin administration, CD administration, moving &amp; handling, nebuliser, oxygen administration, PEG tube care/feeds, restraint, wound management, CPR and syringe driver.</p> <p>Annual performance appraisals are behind schedule and is an area requiring improvement. The care home manager is aware of this and has a corrective plan in place to address this shortfall.</p>

<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>	<p>PA Low</p>	<p>The clinical manager is on call after hours with other RNs. The care home manager and clinical manager, both RNs, are available during weekdays. RN cover is provided 24 hours a day, seven days a week.</p> <p>In the Rotary dementia wing, there were 20 residents. On the morning shift there is one-unit coordinator/RN on duty for three days Tuesday, Wednesday and Friday, who is supported by three caregivers (two long shift and one short shift (0700 to 1300)). On the afternoon shift, there is one RN (across dementia and rest home units) and three caregivers (two long shift and one short shift (1600 to 2100) and on the night shift, there is one RN (across dementia and rest home units) and two caregivers. In addition to cares, caregivers in the dementia wing are responsible for medication administration and kitchen assistant duties. Caregiver staff, the unit coordinator for the dementia unit, the activities staff who work in dementia and family interviews (dementia) stated that they felt there were insufficient numbers of staff available.</p> <p>In the Hospital unit, there were 21 residents. On the morning shift, there is one unit coordinator/RN or RN on duty seven days a week, who is supported by four caregivers (three long and one short 0730 to 1330). On the afternoon shift there is one RN and four caregivers (three long and one short (1500 to 2000)), and on the night shift there is one RN and one caregiver.</p> <p>In the two rest home units there were 36 residents. On the morning shift there is one unit coordinator/RN on duty from Monday to Friday with an RN available on weekends. Three (long shift) caregivers cover the AM shift. On the afternoon shift there is one RN (across dementia and rest home units) and three caregivers (two long and one short (1600 to 2130) and on the night shift there is one RN (across dementia and rest home units) and two caregivers.</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. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. Electronic files are backed up using cloud-based technology. Residents' files demonstrated service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely,</p>	<p>FA</p>	<p>There is an implemented Bupa admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The care home manager and clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines</p>



<p>and respectful manner, when their need for services has been identified.</p>		<p>access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The nine admission agreements reviewed meet the requirements of the ARCC and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the care home manager or clinical manager are available to answer any questions regarding the admission process.</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>	<p>FA</p>	<p>The service has a policy that 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. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. One file reviewed was of a resident who had been transferred to hospital acutely post-fall. All appropriate documentation and communication were completed. Transfer to the hospital and back to the facility post-discharge was well documented in progress notes. Communication with family was made in a timely manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>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 are no standing orders in use. There are no vaccines stored on site. All staff (RNs, EN and senior caregivers) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses and a senior caregiver interviewed could describe their role regarding medication administration. The service currently uses robotics for regular medication and 'as required' medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the three facility medication rooms. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All medications including the bulk supply order is checked weekly and signed on the checklist form. All eyedrops have been dated on opening.</p> <p>Staff sign for the administration of medications electronically using One-chart. Eighteen electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three-monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted. Those resident's requiring medications</p>

		to be crushed had clear indications and instructions documented by the prescriber on their medication charts.
<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>A kitchen manager oversees the on-site kitchen, and all meals are cooked on site. The kitchen manager was on leave at time of audit and the kitchen was being overseen by a relief cook from a neighbouring BUPA facility. There is a seasonal four-week rotating menu, which is reviewed by a dietitian at organisational level. A resident nutritional profile is developed for each resident on admission which identifies dietary requirements and likes and dislikes, and this is provided to the kitchen staff by registered nurses. The kitchen is able to meet the needs of residents who require special diets, and the cook works closely with the registered nurses on duty. Special diets and likes and dislikes are readily visible on a whiteboard in the kitchen and are updated with any changes to match updated nutritional profiles. Special equipment such as lipped plates and adapted cutlery are available according to resident need. On the day of audit, meals were observed to be well presented. Supplements are provided to residents with identified weight loss issues. Additional snacks are available at all times.</p> <p>The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence expiring January 2022. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. End-cooked and serving temperatures are taken on each meal. Chiller and freezer temperatures are taken daily and are all within the acceptable range. Cleaning schedules are maintained. All foods were date labelled in the pantry, chiller and freezers. 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. Resident meetings, surveys and the food comments book allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food.</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 reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The service uses the Bupa assessment booklets and person-centred templates (My Day, My Way) for all residents. The assessment booklet includes falls, Braden pressure area, skin, mini nutritional, continence, pain (verbalising and non-verbalising), activities and cultural assessment. These are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time.</p> <p>InterRAI assessments had been completed for all long-term residents' files reviewed. Areas triggered were addressed in the care plans reviewed. Initial interRAI assessments and reviews are evident in printed format in all resident files (link 1.3.3.3).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Nine resident files were reviewed across a range of conditions including (but not limited to) pressure injury care, communication, diabetes, dementia, behaviour that challenges, falls, and weight loss. In all files reviewed the care plans were comprehensive, addressed the resident need and were integrated with other allied health services involved in resident care. Service integration was evidenced by documented input from a range of specialist care professionals, including the podiatrist, dietitian, wound care specialist and mental health care team for older people. Relatives and residents interviewed all stated they were involved in the planning of resident care. In all files reviewed there is evidence of resident and relative involvement in care planning. Activity assessments were completed by the activities staff within three weeks of admission. Care plans reviewed provided evidence of individualised support. Short-term care plans are in use for short-term needs and changes in health status. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</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>	<p>FA</p>	<p>The registered nurses complete care plans for residents. Progress notes in all files reviewed had detailed progress which reflected the interventions detailed in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative's health status, and this was confirmed by family members interviewed, who stated they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident health status was viewed in the resident files sampled on the family/whānau contact form. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is employed to assess and assist residents' mobility and transfer needs.</p> <p>Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds.</p>

		<p>Wound monitoring has occurred as documented and there were photos to show wound progress. There were 10 current wounds including two chronic wounds, six skin tears, one abrasion and one grade 2 pressure injury (DHB acquired). There was evidence of wound nurse specialist involvement in chronic wound management.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.</p> <p>Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. All monitoring requirements including neurological observations had been documented as required.</p> <p>Care plans have been updated as residents' needs changed. The GP interviewed was complimentary of the service and care provided.</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 service employs an activity coordinator (in training) and two activity assistants covering Monday to Sunday between them, planning and leading activities in the home. There are set Bupa activities including themes and events which the activities team add to in order to individualise activities to resident need and preferences within the facility. A weekly activities calendar is distributed to residents, posted on noticeboards and is available in large print. On the days of audit residents were observed participating in activities. The activities coordinator seeks verbal feedback on activities from residents and families to evaluate the effectiveness of the activity programme, enabling further adaptation if required. Residents interviewed were positive about the activity programme.</p> <p>Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. There are weekly outings to places of interest in the community and there are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and other cultural festive days are celebrated. There are visiting community groups such as the local kindergarten, church groups and canine friends dog therapy. There is also a visiting music therapist. The activity team provide a range of activities which include (but are not limited to) exercises, mini-golf, crafts, games, quizzes, entertainers, cooking and bingo.</p> <p>The activity team are involved in the admission process, completing the initial activities assessment, and have input into the cultural assessment, 'map of life' and 'my day my way' adding additional information as appropriate. An activities plan is completed within timeframes, a monthly record of attendance is maintained, and evaluations are completed six-monthly. The activities staff designated to work in the</p>

		<p>dementia unit (Mon- Sun) reported that it can be difficult to complete activities with residents because their assistance is required to assist the caregivers in providing cares (link 1.2.8.1).</p> <p>Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities according to their preferences.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The nine resident care plans reviewed had been evaluated by the registered nurses if there was a change in resident health status. The resident care plans are evaluated and updated six monthly or prior should there be a change in the resident's care needs. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Six monthly multi-disciplinary reviews (MDR) and meeting minutes are completed by the registered nurse with input from caregivers, the GP, the activities coordinator, resident and family/whānau members and any other relevant person involved in the care of the resident. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Bupa Stokeswood facilitates access to other medical and non-medical services. Referral to other health and disability services is evident in the sample group of resident files. The RNs initiate referrals to nurse specialists, and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Referral documentation is maintained on resident files. The unit coordinator interviewed gave examples of where a resident's condition had changed, and the resident had been reassessed for a higher or different level of care. Discussion with the registered nurses identifies that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>
<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</p>	FA	<p>There are policies and documented processes regarding chemical safety and waste disposal in place. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available and readily accessible for staff. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff and were seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.</p>

substances, generated during service delivery.		
<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 building warrant of fitness, which expires June 2021. A request book for repairs is maintained and signed off as repairs are completed. There is a part-time maintenance officer who carries out the 52-week planned maintenance programme. The maintenance officer is also on call after hours for urgent matters. The checking and calibration of medical equipment including hoists, has been completed annually and is next due September 2021. All electrical equipment has been tested and tagged is due to be retested in June 2021. Hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is safe access to all communal areas. The external areas are landscaped and accessible.</p> <p>Residents in the secure dementia unit can freely access a secure outdoor area which is landscaped with raised beds and a vegetable garden, has appropriate pathways, seating and shade.</p> <p>The caregivers, RNs and unit coordinators interviewed stated that they have all the equipment required to provide the care documented in the 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>Visual inspection evidenced toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. All bedrooms in the hospital have a single ensuite, single toilet in the rest home and shared shower facilities and dementia community/unit shared facilities. Handrails are appropriately placed in ensuite bathrooms, communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. There is a mobility bathroom with shower bed available. There are sufficient showers and toilets for the residents in all units. There are communal toilets located near the lounge/dining rooms. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Residents interviewed reported their privacy is maintained at all times.</p>
Standard 1.4.4: Personal	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility equipment. Residents are encouraged to personalise their bedrooms with personal</p>

<p>Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>belongings as viewed on the day of audit. Staff interviewed reported that they have more than adequate space to provide care to residents.</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>	<p>FA</p>	<p>There are large and small communal areas. Activities occur in all lounges and dining areas which are large enough to cater for the activities on offer, are accessible and can accommodate the equipment required for the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The lounge and dining areas are spacious, inviting and appropriate for the needs of the residents. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance during the audit.</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>	<p>PA Low</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All laundry is done on site. There are clearly defined clean and dirty areas with separate entry/exit.</p> <p>There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaners' trolley were labelled. Sluice rooms were kept locked when not in use. Residents and family interviewed reported satisfaction with the cleaning service, however, were not satisfied with the system for labelling resident clothing and the service's ability to ensure individual resident clothing was not used communally. Complaints relating to the smell of the carpet in dementia unit were also evidenced during interviews with family (dementia) and in the recent 2020 satisfaction survey results.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency</p>	<p>FA</p>	<p>There are emergency/disaster management plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. Fire evacuation drills take place every six months. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup.</p> <p>Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are available.</p>

and security situations.		<p>There are civil defence kits that are regularly checked. There is water stored (water tank) to ensure for three litres per day for three days per resident with plans in place to increase this amount as per the civil defence recommendations. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. Residents were sighted to have call bells within reach during the audit and this was confirmed during resident and relative interviews. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. The facility is secured at night. Access by public is limited to the main entrance. The dementia community/unit has a secure entrance.</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>All bedrooms and communal areas are appropriately heated, have ample natural light and ventilation. The facility has central heating that is thermostatically controlled. Staff and residents interviewed stated that this is effective. All bedrooms and communal areas have at least one external window. There is one monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <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>	FA	<p>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control coordinator (ICC) who is responsible for infection control across the facility as detailed in the ICC job description (signed copy sighted on day of audit). The ICC oversees infection control for the facility, reviews incidents on Riskman and is responsible for the collation of monthly infection events and reports. The infection control committee and the Bupa governing body are responsible for the development and review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There were two influenza type outbreaks in the last 12 months which were appropriately managed with public health being notified and Stokeswood placed into isolation. No visitors were allowed onsite during these periods while all residents with flu like symptoms had swabs taken and were tested for COVID-19.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning, doffing and use of PPE. During the lockdown period daily head of department meetings were instigated and stocks of PPE increased as an emergency preparation measure in addition to the maintenance of regular stock levels.</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>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Bupa Stokeswood. The ICC liaises with the infection control committee who meet two monthly and as required (monthly during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The ICC has completed online training in infection control. External resources and support are available through the Bupa quality &amp; risk team, external specialists, microbiologist, GPs and nurse practitioners, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by Bupa head office.</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 and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, the infection control team, and training and education of staff. Infection control procedures developed in respect of care, the kitchen, laundry and housekeeping incorporate the principles of infection control. Policies are updated regularly and directed from Bupa head office.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The ICC 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, and staff have completed infection control education in the last 12 months. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice, education packages and group benchmarking. The ICC has also completed infection control audits.</p> <p>Resident education occurs as part of providing daily cares and as applicable at resident meetings.</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>	<p>FA</p>	<p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Bupa surveillance policy. The ICC uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the infection control meetings. Meeting minutes are available to staff.</p> <p>Infections are entered into the electronic database (RiskMan) for benchmarking. Corrective actions are established where trends are identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 two (hospital level) residents using low beds as restraints, and two (hospital level) residents with bedrails as enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours.</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>	<p>FA</p>	<p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities for the restraint coordinator (hospital unit coordinator/RN) are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p>
<p>Standard 2.2.2: Assessment</p>	<p>FA</p>	<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.</p>

<p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. Ongoing consultation with the resident and family/whānau are evident. The files for two hospital level residents using low beds as a restraint and one hospital level resident using bedrails as an enabler were reviewed. The completed assessments considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>PA Low</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to trial (as appropriate) before restraint is used.</p> <p>The care plans reviewed of two residents with restraint, identified observations and monitoring although monitoring records indicate that it is not occurring at the frequency determined in the restraint assessment (two hourly).</p> <p>Restraint use is reviewed through the three-monthly evaluation, two-monthly restraint meetings and six-monthly multidisciplinary meeting which includes family/whānau input. A restraint register is in place, providing a record of restraint use and is completed for residents requiring restraints and enablers.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred 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.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>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.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	Staff files selected for review included staff who were employed from 2018 onwards. Staff reported that they complete an orientation programme, but this was missing in a selection of the staff files reviewed.	Evidence of staff completing their orientation programme were missing in three of ten staff files audited.	<p>Ensure staff submit documented evidence of completing an orientation programme.</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</p>	PA Moderate	An education and training programme is developed by the Bupa head office that address all required areas. In addition to in-service	Evidence of annual performance appraisals were missing in four of eight staff files reviewed of staff who have been employed for over one year.	Ensure performance appraisals are completed

<p>and effective services to consumers.</p>		<p>training, staff complete a range of competency assessments.</p> <p>Evidence of annual performance appraisals were missing in a selection of staff files. This has been identified as an area requiring improvement by the care home manager with corrective actions being implemented at the time of the audit.</p>		<p>annually, in line with the organisation's policies and procedures.</p> <p>60 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Low</p>	<p>The clinical manager is on call after hours with other RNs. The care home manager and clinical manager, both RNs, are available during weekdays. RN cover is provided 24 hours a day, seven days a week. There are concerns identified around the current staffing in the dementia unit.</p>	<p>In the dementia unit (20 residents) three caregiver staff are rostered on AMs and PMs (two long shift and one short shift). Caregivers who work in the dementia unit stated that they do not have enough staff to safely complete caregiver responsibilities including cares, medication administration, and kitchen assistant duties. The AM shift staff reported that at times they need to stop their medication administration to assist with cares. This is of particular concern when caregiver vacancies have been unable to be filled (January/February 2021: four-night shifts, three AM shifts, one PM shift). One family from the dementia unit discussed their concern regarding poor staffing levels. The part time RN who works in dementia (three days/week) reported that she is unable to assist with cares because her time (three days a week) is spent on documentation. The activities staff who works in dementia reported that they have difficulty doing their activities job because the caregiver staff require their assistance with cares. The care home manager confirmed that the staffing roster in dementia requires review. Other factors that have impacted on staffing levels include the high acuity of the residents</p>	<p>Ensure that the staffing in the dementia unit provides for the safe care of the residents with adequate numbers of staff.</p> <p>60 days</p>

			in the dementia unit (noting none are due for reassessment).	
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	All nine resident files reviewed documented a care plan using the Bupa template. Long-term care plans and interRAI assessments were not all completed within the required timeframes.	Five of nine resident files showed long-term care plans and/or interRAI assessments were not completed within the timeframes stated in policy. Of these, three were new interRAI assessments (one rest home, one hospital, one dementia), one hospital interRAI reassessment, one rest home initial long-term care plan and one dementia six-monthly care plan evaluation.	<p>Ensure all interRAI assessments and care plans are completed and/or evaluated within the required timeframes according to policy.</p> <p>90 days</p>
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	PA Low	There is a documented process for labelling resident clothing and detailed cleaning routines for facility fixtures and fittings. Residents and family interviewed reported satisfaction with the cleaning service, however, were not satisfied with the system for labelling resident clothing and the service's ability to ensure individual resident clothing was not used communally. Complaints relating to the smell of the carpet in dementia unit were	<p>(i) Resident clothing is not always identifiable as belonging to a certain individual. The laundry room contained three tubs of unlabelled/lost clothing.</p> <p>(ii) The cleaning of the carpet in the dementia unit is no longer effective due to the carpets age and saturation with urine.</p>	<p>(i) Ensure processes are implemented to correctly identify and manage resident clothing.</p> <p>(ii) Ensure the urine smell in the carpet in the dementia unit is removed.</p>

		also evidenced during interviews with family (dementia) and in the recent 2020 satisfaction survey results. The smell of urine was very noticeable in certain corridor areas of the dementia unit and remained so even after cleaning on day one of the audit.		90 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>	PA Low	Assessments and care plans identify specific interventions or strategies to trial (as appropriate) before restraint is used. Two residents using low beds as a restraint are scheduled to be monitored two-hourly when the restraint is in place. Monitoring records failed to indicate that this is occurring as scheduled.	Both residents using low beds as a restraint have been assessed as requiring monitoring two hourly while the restraint is in place. On review of both residents' files, monitoring of restraint use was not as frequent as required.	<p>Ensure restraint monitoring occurs at the frequency determined in the restraint assessment and as documented in the resident's care plan.</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.