

Bupa Care Services NZ Limited - Parklands Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Bupa Care Services NZ Limited

Premises audited: Parklands Hospital

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

Dates of audit: Start date: 6 December 2021 End date: 7 December 2021

Proposed changes to current services (if any): The service was also certified in June 2021 to provide residential disability-physical level care and dementia level care. The table above should identify these certified levels.

Total beds occupied across all premises included in the audit on the first day of the audit: 105



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Bupa Parklands is part of the Bupa group. The service is certified to provide rest home and hospital (psychogeriatric, geriatric, and medical), dementia and residential disability – physical level care for up to 127 residents. On the days of audit there were 105 residents. The newly renovated dementia unit remains closed.

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

The service is managed by an interim care home manager (RN) who has been in the role at Parklands since January 2021. The manager has experience in aged care management and is on a year contract while the previous care home manager is on maternity leave. The clinical manager has been in the role for a year and has 17 years' experience with other Bupa services in clinical management roles. There are three-unit coordinators (RNs) who oversee two communities each. The management team is supported by the wider Bupa management team including a regional operations manager.

The service has addressed three of the six previous partial provisional shortfalls around the quality system, environment, and privacy. Further improvements continue to be required around care plan interventions, kowhai outdoor area and securing the unit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Residents and family interviewed verified ongoing involvement with the community

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is a strategic plan and annual quality, and risk management plans are in place. These define the scope, direction and objectives of the service and the monitoring and reporting processes. The care home manager and the clinical manager provide leadership, and both are registered nurses with a current practising certificate. The human resource management system is documented in policy with recruitment completed as per policy. There is an annual training plan that is implemented.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents' records reviewed provided evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrated service integration and are reviewed at least six-monthly. Residents' files included three monthly reviews by the general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three- monthly by the general practitioner.

An integrated activities programme is implemented that meets the needs of aged care residents. The programme includes community visitors and outings, entertainment, and activities.

All food and baking is done on site. Residents' nutritional needs are identified and documented. Choices are available and are provided. The organisational dietitian reviews the Bupa menu plans. Nutritional snacks are available 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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Bupa Parklands has a current building warrant of fitness and reactive and preventative maintenance occurs. All equipment is tagged and tested annually. There is easy access to all internal and external communal areas with seating and shade provided in the garden areas. There is wheelchair access to all areas. The outdoor areas are safe, easily accessible, and secure. The dementia areas are secure.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies. There is a staff member on duty on each shift who holds a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort with the focus being on maintaining a restraint free environment. Staff receive regular education and training on restraint minimisation and around management of challenging behaviour. During the audit there were nine resident using restraints and no residents using enablers.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Results are benchmarked within the organisation. Staff have been provided with education around isolation procedures and maintain competencies in relation to infection control. Adequate supplies of personal protective equipment were sighted during the audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	17	0	2	1	0	0
Criteria	0	47	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and relatives on entry to the service. The interim care home manager maintains an electronic record of all complaints, both verbal and written. There have been nine complaints received since the previous partial provisional audit held in June 2021. 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).</p> <p>The two HDC complaints which were open at the previous partial provisional audit remain open. All information requested has been sent, and provisional letters to the complainants have no recommendations. The service is waiting on final confirmation of resolution from the HDC.</p> <p>Discussions with two hospital level residents (one on a younger person with a disability (YPD) contract, and one funded by ACC), and one rest home level resident confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. Relatives commented that the manager was very helpful and worked with the families to manage issues raised. The interim care home manager, the clinical manager and staff interviewed (nine registered nurses including three-unit coordinators, eight caregivers, four activities assistants, one cook and one maintenance) were all aware of their responsibilities around the complaint process in relation to their role.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Family/whānau communication is recorded on the family/whānau communication record, which is held in each resident's file. Electronic accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms identified family are kept informed. Relatives interviewed (four psychogeriatric and two hospital) reported there was very good communication between the staff and relatives. They felt well informed of any changes as were involved in decision making.</p> <p>The GP stated that the service is proactive with keeping family involved and relatives were invited to GP appointments and reviews. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. There were no residents requiring interpreter services.</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 Parklands is currently certified to provide; psychogeriatric, hospital (medical and geriatric); residential disability – physical, dementia and rest home level care services for up to 127 residents. On the day of audit there were 105 residents. This included 47 hospital residents (including seven YPD, and one resident under ACC). There was one rest home (ARC contract) and 57 residents across the three psychogeriatric communities (on ARHSS contracts). The newly renovated 16-bed Kowhai wing currently remains closed.</p> <p>Bupa Parklands is a two-storey building with all care services being provided on the first floor. Corporate offices and staff facilities are located in the second level.</p> <p>The service is managed by an interim care home manager (RN) who has been in the role at Parklands since January 2021. The manager has experience in aged care management and is on a year contract while the previous care home manager is on maternity leave. The clinical manager has been in the role for a year and has 17 years' experience with other Bupa services in clinical management roles. They are supported by three-unit coordinators (RNs). The management team is supported by the wider Bupa management team including a regional operations manager (also based at Parklands).</p> <p>The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.</p> <p>A vision, mission statement and objectives are in place. Progress towards the achievement of annual goals for 2020 have been evaluated by the quality team. The annual goals for 2021 have been developed and include improvements to the activity programme, reducing pressure injuries by 50% and completing person-first training. Discussion with the care home manager and review of the quality programme document a focus on continuing to improve communication and staff education.</p>
<p>Standard 1.2.3: Quality And Risk</p>	<p>FA</p>	<p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>(Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. A quality and risk management programme is documented. A quality plan is documented annually with documentation reviewed confirming that a review of the 2020 plan has been completed. Quality initiatives for 2021 have been reviewed through the year at the quality meetings. There is a documented meeting schedule, and a range of meetings are held. These include (but not limited to) bi-monthly quality meetings, monthly community staff meetings, bi-monthly H&S meetings, quarterly infection control meeting, quarterly restraint meetings, monthly qualified staff meeting, weekly clinical review forums and bi-monthly meetings. Meeting minutes sighted evidenced staff discussion around accident/incident data and trends, health and safety, infection control, internal audit outcomes, complaints/concerns, and survey feedback. All meeting minutes are posted in the staffroom for staff to read. Information from key meetings such as quality meetings are disseminated down to community staff meetings. The previous shortfall around implementing corrective actions as a result of data analysis has been addressed with corrective actions ongoing around falls minimisation, and these are discussed at meetings. A folder is maintained of all corrective actions identified which evidences discussion at meetings and progression towards compliance.</p> <p>The 2021 satisfaction survey has been completed; however results were not yet available. One resident meeting has been held in 2021 due to Covid restrictions and staffing issues, however, residents interviewed felt they have the opportunity to feedback concerns or suggestions to any member of staff. The meeting minutes evidenced the residents have the opportunity to provide feedback around all aspects of the service.</p> <p>The previous shortfall around implementing corrective actions as a result of data analysis has been addressed with corrective actions ongoing around falls minimisation. These are discussed at meetings. The satisfaction survey results for 2020 were displayed on notice boards around the facility for residents and relatives to read. This was also included in newsletters provided to relatives and residents and relatives stated if they had any concerns, it was dealt with promptly. Newsletters are sent to residents and relatives to inform them of changes, what's on around the facility, and upcoming events.</p> <p>There is a documented internal audit programme that covers all aspects of the service. Internal audits have been completed as per schedule and a corrective action plan where shortfalls have been identified.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits, and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings. The committee is representative of the facility.</p> <p>Falls management strategies include assessments after falls and individualised strategies. Falls minimisation is a current focus where the service was above benchmark for falls. The service has a corrective action plan implemented to reduce falls as a result of the MOH complaint. Benchmarking data for falls evidences the service is under the benchmark for Bupa facilities.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual reports are completed electronically for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes.</p> <p>Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations are commenced where there is an un-witnessed fall, if there is a head injury or for any other reason identified by the care staff. Where possible, opportunities to minimise future risks were identified and implemented. Wound charts were implemented where residents had sustained skin tears and had an associated short-term care plan documented. All documentation in relation to the injury including neurological observations if taken were scanned onto that incident report. Relatives were notified for each incident. Relatives interviewed felt they were informed promptly of any incident. All incident reports are reviewed and signed off by the clinical manager.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. Since the previous certification audit, there were a total of 11 section 31 notifications have been made to the Ministry of Health including pressure injuries, two suspected outbreaks, repair of the sprinkler system, two fractured femur, and a resident choke. There have been three notifications required in 2021 including pressure injuries, and a 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>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files (one clinical manager, one unit coordinator, one registered nurse, and five caregivers including one from each unit) reviewed, evidenced implementation of the recruitment process, employment contracts, and completed orientation. Annual performance appraisals have been completed annually. A register of practising certificates is maintained via the Nursing Council website.</p> <p>There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. Study days are held throughout the year for staff to attend to ensure they complete the required training. Moving and handling training has been regularly provided to staff by the physiotherapist and all required staff have up-to-date moving and handling competencies that are completed annually. Clinical staff complete competencies relevant to their role. A competency programme is in place with different requirements according to work type (e.g., caregiver, registered nurse, and cleaner). Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files). Registered nurse competencies include (but not limited to), wound, medication administration and restraint competencies.</p> <p>There are 26 RNs including the unit coordinators and the clinical manager. Sixteen of the 26 RNs including the unit coordinators and the clinical manager are trained and competent to complete interRAI assessments. The RNs, unit coordinators and the clinical manager have completed syringe driver training and have access to external training.</p>

		<p>Additional education is provided via toolbox talks. Registered nurses have access to external training.</p> <p>The caregivers undertake Aged Care Education (Careerforce). Currently there are 32 caregivers who have achieved level 2, 24, have achieved level 3, and 13 have achieved level 4. There are two in the process of completing training. A total of 32 have completed the dementia standards. Currently there are 35 staff working in the PG units including four who have recently joined the psychogeriatric (PG) units. Twenty-two staff have completed the required dementia standards, a further nine have enrolled. Staff who have not completed the required NZQA standards and who work in the PG units do not ever work by themselves.</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>FA</p>	<p>An organisational staffing policy aligns with contractual requirements and includes skill mixes. The wage analysis schedule is based on the safe indicators for aged care and dementia care and the roster is determined using this as a guide. A report is provided fortnightly from head office that includes hours and whether there are over and above hours.</p> <p>The roster is flexible to allow for the increase in resident numbers. Currently there is sufficient employed staff to cover the roster. Adequate RN cover is provided 24 hours a day, seven days a week. Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations within contractual timeframes.</p> <p>Each care home manager and clinical manager from the southern region provide the on-call service after hours on a rotating roster. The care home manager, clinical manager and unit coordinators reported that extra staff can be called on for increased residents' requirements. The RNs are also available to assist with cares if required. One unit coordinator oversees Matai unit, one for Rata and Ngaio and one for Rimu and Kauri.</p> <p>Activities staff are rostered seven days a week in the psychogeriatric communities and four days a week in the hospital communities. An additional registered nurse is rostered across all shifts. Occasionally enrolled nurses cover nightshift with RN oversight from a neighbouring unit.</p> <p>Matai community has 31 dual-purpose beds, 29 residents - 28 hospital (including 1x ACC, 5x YPD), and 1x RH</p> <p>There are four caregivers 0700 – 1500, one caregiver 0800 - 1300 and one caregiver 0900 – 1300.</p> <p>There are two caregivers 1500 – 2300, one caregiver 1500 – 2200, and one caregiver 1700 – 2100. There is one caregiver 2300 – 0700 with an RN.</p> <p>Ngaio community has 20 hospital beds, 18 hospital residents including 2x YPD</p> <p>There are two caregivers 0700 – 1500, one caregiver 0800 – 1300 and one caregiver 0900 – 1300.</p> <p>There is one caregiver 1500 – 2300, one caregiver 1500 – 2200, one caregiver 1630 – 2030, and one caregiver 1700 – 2100. There is one caregiver and one RN overnight.</p>

		<p>Rimu community has 20 PG Beds, 20 PG residents</p> <p>There are two caregivers 0700 – 1500, one caregiver 0800 – 1300 and one caregiver 0900 – 1300.</p> <p>There is one caregiver 1500 – 2300, one caregiver 1500 – 2200 and one caregiver 1600 – 2200, one caregiver overnight.</p> <p>Rata Community has 20 PG beds, 18 PG residents</p> <p>There are two caregivers 0700 – 1500, one caregiver 0800 – 1300 and one caregiver 0900 – 1300.</p> <p>There is one caregiver 1500 – 2300, one caregiver 1500 – 2200 and one caregiver 1600 – 2200, one caregiver overnight.</p> <p>Kauri Community has 20 PG beds, 19 PG residents</p> <p>The draft roster identifies two caregivers 0700 – 1500, one caregiver 0800 – 1300 and one caregiver 0900 – 1300.</p> <p>There is one caregiver 1500 – 2300, one caregiver 1500 – 2200 and one caregiver 1600 – 2200, one caregiver overnight</p> <p>One unit coordinator oversees Matai (dual purpose) unit, one unit coordinator oversees Rata (PG) and Ngaio(dual purpose) and one unit coordinator for Rimu and Kauri. (both PG). In addition to the unit coordinators, there is one registered nurse rostered on morning and afternoon shifts. Three RNs cover nightshifts, two RNs cover the dual-purpose units, and one covers the PG units. There is one registered nurse overnight who oversees the three PG units.</p> <p>Kowhai (dementia) 16-bed unit currently closed.</p> <p>All registered nurses have current first aid certificates.</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</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors recorded and fed back to the supplying pharmacy. The medication rooms and fridges have temperatures recorded daily and these are within acceptable ranges for all the medication/treatment rooms. There are no standing orders.</p> <p>Registered nurses are responsible for the administering of medications and have completed annual medication competencies and annual medication education. Caregivers who act as second checker have also completed medication competencies. The service uses an electronic medication management system.</p> <p>Twelve electronic medication charts were reviewed (five hospital including two YPD, one rest home and six psychogeriatric). Photo identification and allergy status were on all 12 charts. All medication charts had been reviewed by the GP at least three-monthly. Self-medication assessments have been completed for one self-</p>

guidelines.		<p>medicating resident at rest home level (tracer). Eye drops and ointments are dated on opening.</p> <p>Antipsychotic management plans are used for residents using antipsychotic medications when medications are commenced, discontinued, or changed. The general practitioner reviews the antipsychotic management plans for residents with stable behaviours and a geriatrician reviews the management plans for residents with acute changes in behaviour. Medication is optimised by considering the number of medications already prescribed, individual behaviours, individual fall trends and the number of prn medication used. When prn medication is over utilised, the medication will be prescribed as regular medication. Medication effectiveness are documented in the progress notes and on the medication chart. Treatment plans for chronic pain is individualised.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The cook oversees the procurement of the food and management of the kitchen. All food services staff have attended food safety training. There are food service manuals and a range of policies and procedures in place to guide staff. There is a well-equipped clean kitchen, and all meals are cooked on site. Each community has a kitchenette/ dining area, food is transported to each area in bain maries and is served to the residents by caregivers. The service has a current food control plan displayed expiring on 22 September 2022. Kitchen fridge, food and freezer temperatures were monitored and documented daily; these were within safe limits.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen by the registered nurse or unit coordinator. Special diets were noted on the kitchen noticeboard which is able to be viewed only by kitchen staff. The national menus have been audited and approved by an external dietitian in November 2021. There was evidence that there are additional nutritious snacks available over 24 hours. The menu provides for alternative food choices and modified textures.</p> <p>The cook could describe the needs of specific residents including those with recent weight loss or swallowing difficulties.</p> <p>During the audit, meals were observed to be hot and well-presented and sufficient number of staff were available to assist residents with their meals. Specialised utensils are available. Fortified supplements are available and mixed in the kitchen. Plenty fluids were available.</p> <p>Facility meetings and surveys provide feedback on the meals and food service. Residents and families interviewed were very happy with meals provided and confirmed that alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.4: Assessment Consumers' needs,</p>	FA	<p>Files reviewed indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments and Bupa assessment booklets had been completed for all long-term residents' files reviewed. The assessment booklet provides in-depth assessment</p>

<p>support requirements, and preferences are gathered and recorded in a timely manner.</p>		<p>across all domains of care. Initial interRAI assessments and reviews are evident for all resident files reviewed.</p> <p>Resident files reviewed identify that risk assessments 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. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments are appropriately completed according to need. For the resident files reviewed, the outcomes from interRAI assessments and risk assessments are reflected into care plans.</p> <p>All falls had a post fall assessment, pain and skin assessment completed and attached to the incident report form on the electronic incident management system. Risk assessment scores are updated in the care plan. A physio assessment is completed for all residents within a few days of admission to determine level of mobility and the type of transfer equipment and hoist slings size. A picture transfer plan is developed by the physiotherapist and the mobility plan with interventions are developed by the registered nurse. Mobility changes or a change of transfer equipment are noted in the care plan.</p> <p>Pain assessments were completed six monthly in the PG units and the resident with the current pressure injury had a pain assessment completed more often. Alternatives to medication is considered and include heat therapy and comfort cares. Registered nurses interviewed could describe how they closely observe for pain cues in residents are cognitively impaired or where communication is compromised. Staff completed education in management of pain in May 2021. Progress notes and the electronic medication management chart evidence prn medication effectiveness is recorded.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Care plans reviewed were comprehensive and demonstrated service integration and demonstrated input from allied health. The interRAI assessment process informs the development of the residents' care plan. All resident care plans were resident-centred and documented their support needs. Care plans are easy to read and where changes occur, care plans are updated. All new updates are incorporated into the care plan and the care summary. The shortfall identified at the partial provisional audit related to identifying all the needs in the long-term care plan has not been addressed.</p> <p>Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Family communication and meetings were evidenced in the documentation reviewed. Long-term care plans in the psychogeriatric unit (PG) detail care and support for behaviours that challenge, including triggers, associated risks, and management. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved. Staff interviewed reported they found the care plans easy to follow. There was evidence of service integration with documented input from a range of specialist care professionals. Psychogeriatric and mental health team support and advice was evidenced and documented.</p> <p>All care plans included chronic pain interventions including alternatives were considered.</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>There is specialist input into resident's well-being in the psychogeriatric unit. The GP interviewed confirm the visiting geriatrician provide support with facilitating admissions to the DHB when required. Strategies for the provisions of a low stimulus environment could be described by the care team.</p> <p>Residents and families interviewed, reported their needs were being met. Family members interviewed praised the service, the care staff, and the management team. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Contenance products are available and resident files included 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. Caregivers and RNs interviewed stated there is adequate continence and wound care supplies.</p> <p>Comprehensive wound assessment, wound management and evaluation forms and short-term care plans were in place for wounds. All wound care plans included a short-term care plan and written progress notes to assist review and evaluation of the wound. There was evidence of regular wound swabs taken for chronic wounds.</p> <p>On the day of audit, there were eight wounds documented for the two hospital communities. The wounds included skin tears, one chronic ulcer, one surgical wound and one stage-three pressure injury. The community wound care specialist had reviewed the pressure injury and d care plans reflect the specialist input.</p> <p>There were twenty wounds in the three PG communities including one cancerous lesion, a stage three pressure injury, one peg stoma, two leg ulcers and fifteen superficial wounds including skin tears. All wounds had assessments, plans and evaluations recording progression towards healing or deterioration of the wounds, including regular photos. Wound care specialist input was documented for pressure injuries.</p> <p>Short-term care plans were in place for short-term/acute needs, these are reviewed regularly and either ongoing or added to the long-term care plan interventions.</p> <p>Monitoring charts were in use; examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, restraint, food, and fluid, turning charts, syringe driver monitoring, and behaviour monitoring as required. All monitoring forms evidenced that the required observations were being completed in the prescribed timeframes as stated in the care plans.</p> <p>All residents have a transfer and /mobility plan completed by the physiotherapist on admission and as part of the fall's prevention strategy plan after a reoccurring fall. Care plans are resident centred and include assistance required for transfers from the bed, chair, and toilet (link1.3.5.2). Sling hoist size needed for hoist transfers are documented in the transfer plan. All support staff including registered staff completed moving/handling competencies annually. These were up to date. All staff completed moving/handling training in 2020 and further training has been provided in February and April 2021. A moving handling internal audit was completed 25 May</p>

		<p>2021 with a result of 100%. This is an improvement on the previous audit score of 98%.</p> <p>There is evidence of occupational therapy involvement in the seating requirements for one YPD resident and one hospital resident with a sacral pressure injury. Staff were observed to follow a two person assist for hoist transfers.</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 activities team is overseen by the Bupa occupational therapist. The team comprises of seven other activities persons. All of the activity staff have completed Careerforce dementia education modules and one is near completing a diversional therapist qualification. The Bupa Southern Regional occupational therapist oversees the activity programme and meetings with the activity staff occur regularly. Activity assistants meet weekly with the unit coordinators and interim care home manager to discuss upcoming events.</p> <p>The activity staff attend the Bupa education seminars for activity staff which occurred via zoom meeting. The occupational therapist is the seating assessor.</p> <p>There is a separate programme for the psychogeriatric and hospital level of care residents. Activities were evidenced occurring in each unit. Care staff were observed at various times throughout the day diverting residents from behaviours in the psychogeriatric units. There are 24-hour activity plans documented in the files reviewed for residents in the psychogeriatric units. There are resources available for care staff to use for one-on-one time with the resident. Staff could describe a low stimulus environment.</p> <p>On or soon after admission, a social history is taken and information from this is fed into the care plan and this is reviewed six-monthly, and as part of the care plan review/evaluation a record is kept on individual residents' activities. There are recreational progress notes in the resident's file that the activity assistants complete for each resident every month. The family/resident completes a Map of Life on admission, which includes previous hobbies, community links, family, and interests. The individual activity plan is incorporated into the long-term care plan and is reviewed at the same time as the care plan in all resident files reviewed.</p> <p>Residents are assisted to maximise their potential for self-help and to maintain links with whānau and the community by supporting them to go out into the community. The younger people (YPD) choose activities they wish to participate in (if able). One on one time is spent with the younger persons such as weekly shopping trips, cafes, and coffee. Residents that cannot actively participate in activities are also included.</p> <p>The activities assistants interviewed stated they are part of the six-monthly review where they provided information about the residents' participation in activities.</p> <p>Families and residents interviewed reported satisfaction with the activities provided. Residents from all levels of care were observed to be participating in a wide range of activities. The team is led by an experienced activity coordinator.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The files reviewed demonstrated that all interRAI assessments and care plans reviewed were evaluated at least six monthly or when changes to care occurs. Evaluations records progression towards goals, individual goals are changed when required. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. All changes in health status are documented and followed up.</p> <p>The multidisciplinary review involves the RN, GP, activities staff resident/family, unit coordinator and clinical manager. The files reviewed reflected evidence of family being involved in the planning of care and reviews. In all the files sampled, care plans had been read and signed by EPOA/family. There is at least a three-monthly review by the medical practitioner with majority of residents being seen monthly. The family members interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building holds a current warrant of fitness which expires on 1 January 2022. Fire equipment is checked by an external provider. The maintenance person interviewed described the reactive and preventative maintenance occurs. There is a 52-week planned maintenance programme in place. Electrical equipment has been tested and tagged. Hot water temperature is monitored weekly in resident areas and at hot water cylinders.</p> <p>There are six communities; Kauri, Rimu and Rata (psychogeriatric communities), Matai and Ngaio are rest home and hospital communities. Kowhai community is currently closed for refurbishment.</p> <p>In Kowhai unit new cylinders, circulating pumps and valves have been replaced to keep water temperatures constant under 45 degrees. Lighting and painting colours support a dementia friendly environment. All communal bathrooms include toilets with toilet seats, handrails and working sliding doors. The shortfalls identified at the previous audit related to the toilets and door in Kowhai has been addressed.</p> <p>In the facility, residents are able to bring in their own possessions and are able to adorn their room as desired. There are quiet, low stimulus areas that provide privacy when required. There is a whanau room where private clinical conversations can occur.</p> <p>The living areas and bedrooms (except two in Ngaio, which have vinyl flooring) have carpet surfaces. Kitchenette areas have vinyl flooring as do communal bathrooms/toilets and kitchen areas.</p> <p>The corridors are wide enough around the facility and handrails available to promote safe mobility. Where there is a change of level (ramps) signage is visible. Residents were observed moving freely around the areas with mobility aids where required. There are areas to wander inside and outside with secure garden areas off all three PG units. All working hazardous areas are closed off to residents and staff.</p> <p>Caregivers interviewed felt there is sufficient equipment available to staff in all areas that is calibrated.</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>	<p>FA</p>	<p>There are shared ensuites in four of six communities. The psychogeriatric communities have their own or shared ensuite facilities in Kauri and Rimu communities, there are no ensuite facilities in Rata. There are adequate numbers of communal facilities close to resident rooms. There are shared ensuite shower facilities in Matai, and in Ngaio communities. Kowhai (currently closed) has communal shower facilities. Matai community includes a mix of full ensuites, shared ensuites and sufficient numbers of communal showers. Communal toilets and showers have appropriate signage and locks on the doors to ensure privacy. The shortfall related to the privacy requirement facilities in Kowhai has been addressed.</p> <p>There are adequate numbers of toilets and showers with access to a hand basin and paper towels for residents. The toilets, showers and ensuites have easy clean flooring and fixtures and handrails appropriately placed. All communal showers and toilets allow for mobility equipment. Communal, visitor and staff toilets are available and contain flowing soap and paper towels. Residents interviewed reported their privacy is maintained.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. There is a first aid trained staff member (RN) on every shift. The facility has an approved fire evacuation plan (June 2013) which did not require amendments. Fire drills occur six-monthly. Fire safety training is completed annually (last completed August 2021). Smoke alarms, sprinkler system and exit signs are in place. Since the last audit, further fire walls have been installed.</p> <p>Bupa Parklands have two gas cookers (with cylinders available) and a barbeque for cooking. There is a system for emergency lighting and battery backup. There is also battery backup for electric beds and oxygen concentrators. Oxygen cylinders are available. There are two civil defence kits in the facility and adequate stored water including emergency water tanks. Call bells are evident in resident's rooms, lounge areas, and toilets/bathrooms. Call bell pendants are available for immobile residents in larger rooms/suites. The facility is secured at night. All secure doors are connected to the fire alarms.</p> <p>Keypads are installed at the entrances to Kowhai, but these are not yet operational.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and laboratory that advise and provide</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>feedback/information to the service.</p> <p>Systems in place are appropriate to the size and complexity of the facility. Effective monitoring is the responsibility of the infection control nurse. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infection statistics are included for benchmarking. Corrective actions are established where infections are above the benchmark. All infections are documented monthly in an infection control register.</p> <p>There has been one suspected respiratory outbreak in 2021, one suspected gastroenteritis outbreak and one suspected RSV outbreak in 2020. All isolation precautions were taken, and Public health were notified in a timely manner. Small numbers of residents were affected and no staff.</p> <p>The service has process and procedures implemented to manage the risk posed by Covid -19. Bupa implemented teleconferences during Covid- 19 lock down to ensure staff have the most up to date information these are now approximately monthly. Infection control education is included in the education days provided. Extra toolbox sessions are provided as required. The policies around Covid19 are reviewed regularly to remain up to date, these are currently under review again with the introduction of the traffic light system. All up to date is kept in the 'duty leaders' folder for staff to refer to when management are not available.</p> <p>All residents are screened using the Covid-19 screen form prior to admission. All visitors complete a health questionnaire and evidence vaccine status. Visitors are permitted to visit between set hours during the week and the weekend. Masks are required to be worn at all times while in 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>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.2. There are clear guidelines in the policy to determine what restraint is and what is an enabler. The restraint policy includes comprehensive restraint procedures. There is a bi-monthly restraint committee, and the restraint coordinator is the clinical manager. A monthly restraint report is completed. There is a Bupa national restraint teleconference that includes restraint coordinators across the organisation. They review restraint use and meet six-monthly. An annual benchmarking restraint report is completed for the organisation.</p> <p>There are seven T-belt restraints (four as required only and two bed rails. There were no residents using enablers. Two files were reviewed of residents using restraint. All required documentation including assessment, interventions to manage risk and evaluation was completed. monitoring forms are maintained. There is a restraint register for the facility.</p> <p>Staff have completed training around restraints, enabler and managing behaviours that challenge. Restraint competencies are also completed annually. The restraint standards are being implemented and implementation is reviewed through internal audits, facility restraint meetings, and regional restraint meetings and at an organisational level.</p>

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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>Each resident file reviewed included a recently updated care plan. Care plans documented interventions around management of behaviours that challenge, skin care for a resident with a pressure injury was documented well, care of a resident with diabetes, and weight management plans.</p> <p>The following were identified in two of the three files reviewed from the PG unit i) the resident was recently assessed for a full sling hoist transfer, the care plan was updated however the `personal cares` section was not changed and transfers were still documented as occurring with one assist and the use of a gutter frame ii) when the behavioural care plan was developed, it included transcribing of an antidepressant as part of the intervention statements.</p> <p>Both care plans were corrected, and the issues addressed on the days of the audit.</p>	<p>One care plan (PG unit) reflects contradictory statements related to the level of current ability and type of mobility equipment required.</p> <p>One care plan (PG unit) reflects medication transcribing within the behavioural care plan.</p>	<p>Ensure all current needs are identified in the care plans.</p> <p>Ensure that the care plans do not include transcribing of medication instructions.</p>

				60 days
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	PA Low	There is sliding doors off the living area to a garden area with path, seating, and available shade. The garden area has lockable gates that are not yet secure (link 1.4.7.6). Some landscaping of the area continues.	The outdoor area off the kowhai community continues to be landscaped with further grass being replanted.	<p>Ensure the outdoor area off Kowhai is complete for residents to use.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.7.6</p> <p>The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.</p>	PA Low	The facility is secured at night. Keypads are installed and activated at the entrances of the three psychogeriatric units (Rimu, Rata and Kauri) to keep the units secure however in Kowhai (currently closed but certified for dementia level of care) the installed keypads are not yet operational.	<p>Kowhai community keypads are installed to secure the community, but these are not yet operational.</p> <p>The outdoor garden area keypads are not yet operational.</p>	<p>(i)-(ii) Ensure the Kowhai community is fully secure.</p> <p>Prior to occupancy 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.