# Bupa Care Services NZ Limited - Riverside Care Home and Hospital

## Current Status: 2 April 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Partial Provisional Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Bupa Riverside currently provides rest home and hospital level care for up to 65 residents. On the day of audit, there were 45 residents (23 rest home [including two respite] and 16 hospital residents.

This partial provisional was completed to review a purpose-built 19-bed dementia unit. The dementia unit was originally part of the rest home and has been totally renovated and refurbished. The overall bed numbers (of 65) will not change across the facility. On completion the facility will have a 21 bed rest home, 25 bed hospital and a 19 bed dementia unit.

There are standardised policies and procedures, an implemented annual education programme, core competency assessments and orientation programmes.

Bupa Riverside has an experienced facility manager who is a registered nurse. She has been the facility manager at Bupa Riverside for the last year. She has managed other aged care facilities within the region prior to this appointment. She is supported by a Clinical Nurse Manager (RN).

The three previous audit shortfalls identified under service delivery regarding care plan interventions, wound documentation and medication documentation have been addressed. Further improvements have been identified at this audit regarding care plan timeframes and medication charts.

The partial provisional audit identified that the newly renovated dementia unit, staffing roster, equipment, policies and processes are appropriate for providing dementia level care and in meeting the needs of the residents. Improvements are required around the completion of the building and landscaping, obtaining certificate of public use (CPU), orientating of staff, and securing the unit.

# HealthCERT Aged Residential Care Audit Report (version 4.0)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

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| **Legal entity name:** | Bupa Care Services NZ Limited |
| **Certificate name:** | Bupa Care Services NZ Limited - Riverside Care Home and Hospital |

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| **Designated Auditing Agency:** | Health and Disability Auditing New Zealand Limited |

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| **Types of audit:** | Partial Provisional Audit | | | |
| **Premises audited:** | Riverside Care Home and Hospital | | | |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) | | | |
| **Dates of audit:** | **Start date:** | 2 April 2014 | **End date:** | 2 April 2014 |

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| **Proposed changes to current services (if any):** |
| This partial provisional was completed to review a purpose-built 19-bed dementia unit. The dementia unit was originally part of the rest home and has been totally renovated and refurbished. The overall bed numbers (of 65) will not change across the facility. On completion the facility will have a 21 bed rest home, 25 bed hospital and a 19 bed dementia unit. |

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| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 45 |

## **Audit Team**

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| **Lead Auditor** | XXXXX | **Hours on site** | 4 | **Hours off site** | 2 |
| **Other Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXX |  |  | **Hours** | 1 |

## **Sample Totals**

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| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 4 | Total audit hours off site | 3 | Total audit hours | 7 |

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| Number of residents interviewed |  | Number of staff interviewed | 4 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 5 | Number of staff records reviewed |  | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 10 | Total number of staff (headcount) | 35 | Number of relatives interviewed |  |
| Number of residents’ records reviewed using tracer methodology |  |  |  | Number of GPs interviewed |  |

## **Declaration**

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

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| a) | I am a delegated authority of Health and Disability Auditing New Zealand Limited | Yes |
| b) | Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Not Applicable |
| g) | Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit | Yes |
| h) | Health and Disability Auditing New Zealand Limited has finished editing the document. | Yes |

Dated Thursday, 17 April 2014

## **Executive Summary of Audit**

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| **General Overview** |
| Bupa Riverside currently provides rest home and hospital level care for up to 65 residents. On the day of audit, there were 45 residents (23 rest home [including two respite] and 16 hospital residents.  This partial provisional was completed to review a purpose-built 19-bed dementia unit. The dementia unit was originally part of the rest home and has been totally renovated and refurbished. The overall bed numbers (of 65) will not change across the facility. On completion the facility will have a 21 bed rest home, 25 bed hospital and a 19 bed dementia unit. There are standardised policies and procedures, an implemented annual education programme, core competency assessments and orientation programmes. Bupa Riverside has an experienced facility manager who is a registered nurse. She has been the facility manager at Bupa Riverside for the last year. She has managed other aged care facilities within the region prior to this appointment. She is supported by a Clinical Nurse Manager (RN).  The three previous audit shortfalls identified under service delivery regarding care plan interventions, wound documentation and medication documentation have been addressed. Further improvements have been identified at this audit regarding care plan timeframes and medication charts. The partial provisional audit identified that the newly renovated dementia unit, staffing roster, equipment, policies and processes are appropriate for providing dementia level care and in meeting the needs of the residents. Improvements are required around the completion of the building and landscaping, obtaining certificate of public use (CPU), orientating of staff, and securing the unit. |

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| **Outcome 1.1: Consumer Rights** |
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| **Outcome 1.2: Organisational Management** |
| There are Riverside quality goals for 2014 that include (but not limited to) setting up and providing dementia care services. The service continues to implement the Bupa quality and risk management system.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. A number of toolbox talks have been completed at Riverside. Discussion with management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. 2014 training reviewed includes dementia/delirium and management of behaviours that challenge. The service has employed 12 new staff including (but not limited to) five caregivers, five RNs for the new unit dementia unit. One of the new five caregivers have completed the required dementia standards.  The manager has documented a Staffing Rationale for the dementia unit. The draft roster for the new unit has included 24-hour registered nurse cover specifically in the unit |

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| **Outcome 1.3: Continuum of Service Delivery** |
| The five care plans reviewed were overall written comprehensively, demonstrate service integration, and input from allied health. Changes in health status were noted to be updated in long-term care plans (LTCPs) or short-term care plans (STCPs). The previous audit identified shortfalls around interventions and this has been addressed. Wound assessment and wound management plans are in place. All included assessment and management plans. All wounds have documented evidence they have been reviewed in the timeframe stated and this is an improvement since previous audit. There is an improvement identified around completing care plans within required timeframe. Medication management was reviewed in the rest home/ hospital. The previous audit shortfalls around controlled drug weekly checks and medication signing sheets have been addressed. The service uses four weekly robotic packs. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. There is an improvement required around two medication charts. The main kitchen supplies meals for the home. Residents' food preferences are identified at admission. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. There are food service policies and procedures and a link to a dietitian. Advised that a hot box will be used to transfer food to the dementia unit kitchenette, which is open-plan. The kitchenette has not yet been installed. |

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| **Outcome 1.4: Safe and Appropriate Environment** |
| The service has in place a waste management policy for the safe disposal of waste and hazardous substances including general and special waste. Material safety data sheets are available. There is a sluice in the dementia unit that is to be locked.  The service has renovated part of the existing rest home wing into a secure dementia unit. The unit is still in the process of being completed. There is to be a secure key padded door to the dementia unit from the reception/entrance area. There is also to be another key padded door at the other end of the wing.  The maintenance programme ensures all buildings; plant and equipment are maintained to an appropriate standard or specification where a standard exists for example a planned maintenance system, reactive maintenance system, list of equipment requiring calibration and current calibration reports, list of external contractors and list of preferred suppliers. In the facility, residents are able to bring their own possessions and are able to adorn their room as desired. Consideration is given to residents when purchasing new furniture/equipment. Relevant persons are consulted when selecting furniture, equipment, floor surface coverings. The service has purchased new furniture for the dementia unit. There is a current building warrant of fitness that expires 15/12/14. A certificate of public use will be obtained for the newly renovated wing. The planting/landscaping of the secure garden area is not yet completed.  There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located. There is also adequate space in communal bathrooms, living area, and hallways for residents to wander around. Transfers between rooms can be managed in an ambulance stretcher if required. There is an open-plan dining and lounge area. New furniture has been purchased. The renovations are still in the process of being completed including the installation of the kitchenette. Cleaning and laundry services are well monitored throughout the internal auditing system. Laundry has a clean/dirty flow and chemicals are stored securely. Staff receive training at orientation and through the in-service programme. Laundry service satisfaction is included in the annual survey. The service has in place emergency policies and procedures. Appropriate training, information, and equipment for responding to emergencies is provided. There is an approved evacuation scheme and emergency supplies for at least three days. All key staff hold a current first aid certificate. The facility is secured during the hours of darkness. A call system is in place with appropriately located call buttons/pull cords in all residents’ rooms and communal areas, including toilets and bathrooms. The nurses’ station is also in the lounge. General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas.  Improvements are required around the completion of the building and landscaping including (but not limited to); activating the call bell system, completing the kitchenette, completing the outdoor deck, ensuring the facility and garden area is secure and obtaining a certificate of public use (CPU). |

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| **Outcome 2: Restraint Minimisation and Safe Practice** |
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| **Outcome 3: Infection Prevention and Control** |
| The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service.  The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme. |

## **Summary of Attainment**

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|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 11 | 0 | 5 | 1 | 0 | 0 |
| **Criteria** | 0 | 28 | 0 | 9 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 64 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.2.7: Human Resource Management | Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | All new staff are scheduled to complete orientation next week. | Ensure staff commence orientation to the unit prior to occupancy and complete the induction programme as per Bupa policy | 180 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | One recent hospital admission had 12 days before the care summary was completed and two months before the LTCP was completed. One rest home file identified six weeks from admission until the LTCP was completed. | Ensure documentation including care plans are completed within the required ARC contract timeframes. | 90 |
| HDS(C)S.2008 | Standard 1.3.12: Medicine Management | Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.12.6 | Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | 10 medication charts were reviewed. One medication chart had no starting dates documented by the GP for the prescribed medication on the med chart, one medication chart was a faxed copy and difficult to read. | Ensure medications are dated and charts are legible. | 60 |
| HDS(C)S.2008 | Standard 1.4.1: Management Of Waste And Hazardous Substances | Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.1.1 | Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Low | The sluice room is not yet complete or locked. | Ensure the sluice room is completed and chemicals are secured | Prior to occupancy |
| HDS(C)S.2008 | Standard 1.4.2: Facility Specifications | Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | The service has renovated part of the existing rest home wing into a secure dementia unit. The unit is still in the process of being completed. | Ensure a CPU is obtained for the newly renovated wing and forwarded to the DHB and HealthCERT | Prior to occupancy |
| HDS(C)S.2008 | Criterion 1.4.2.4 | The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | a) The renovations and refurbishments to the new unit are not yet completed; b) the lounge/dining area/kitchenette has not yet completed, c) Water temperatures are yet to be checked in the new unit. | a) and b) Ensure the completed renovations are sited by the DHB prior to occupancy. c) Ensure water temperatures are checked to resident areas. | Prior to occupancy |
| HDS(C)S.2008 | Criterion 1.4.2.6 | Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | The planting/landscaping of the secure garden area is not yet completed. The deck off the lounge has not yet been completed. | Ensure the external area is completed and secure. | Prior to occupancy |
| HDS(C)S.2008 | Standard 1.4.7: Essential, Emergency, And Security Systems | Consumers receive an appropriate and timely response during emergency and security situations. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.7.5 | An appropriate 'call system' is available to summon assistance when required. | PA Low | The call bell system in the dementia unit is the Austco system and this is yet to be activated. | Ensure the call bell system is fully functioning | Prior to occupancy |
| HDS(C)S.2008 | Criterion 1.4.7.6 | The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting. | PA Low | There are keypad locks to be installed at the two entrance doors. The doors off five resident rooms have not yet been adjusted to ensure they cannot be used to exit the building. | Ensure the unit is secure | Prior to occupancy |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
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# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.2: Organisational Management**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

#### Standard 1.2.1: Governance **(**HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Bupa Riverside currently provides rest home and hospital level care for up to 65 residents. On the day of audit, there were 45 residents (23 rest home [including two respite] and 16 hospital residents.  This partial provisional was completed to review a purpose-built 19-bed dementia unit. The dementia unit was originally part of the rest home and has been totally renovated. The overall bed numbers (of 65) will not change across the facility. On completion the facility will have a 21-bed rest home, 25-bed hospital and a 19-bed dementia unit. The intended opening date is 1st May 2014. The manager advised they currently have nine on the waiting list.  Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan.   Riverside set specific quality goals for 2014 including (but not limited to); a) To maintain excellent customer relationships between staff and residents, and between staff members; b) Ensure the resident care is delivered according to legislative requirements and Bupa policy, c) to improve the physical environment to enable residents to enjoy a high quality of life; d) To ensure fiscal balance is maintained; e) To ensure all staff are trained and have skills required to carry out their tasks in the facility.   The service has a number of GPs that visit weekly and a number of residents that have their own GP.  The organisation has a Clinical Governance group. The committee meets two monthly. The aim is to review the past and looking forward. Specific issues identified in HDC reports (learning’s from other provider complaints) are also tabled at this forum. Feedback from this committee is provided back to Riverside in the form of newsletters.  Bupa has robust quality and risk management systems implemented across its facilities. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, psychogeriatric/mental health services. Benchmarking of some key clinical and staff incident data is also carried out with facilities in the UK, Spain and Australia. e.g. Mortality and Pressure incidence rates and staff accident and injury rates. Benchmarking of some key indicators with another NZ provider was commenced Jan 10. The facility manager provides a documented weekly report to Bupa operations manager. The operations manager visits regularly and completes a report to the Director Care Homes & Rehabilitation.   Bupa Riverside has an experienced facility manager who is a registered nurse. She has been the facility manager at Bupa Riverside for the last year. She has managed other aged care facilities within the region prior to this appointment. She is supported by a Clinical Nurse Manager (RN).  There are job descriptions for both positions that include responsibilities and accountabilities. The operations manager provides onsite support for the facility and nurse managers and there is a monthly teleconference with all facility managers in the region.  Bupa provides a comprehensive orientation and training/support programme for their managers. Managers and clinical managers attend annual organisational forums and regional forums six monthly. ARC,D17.3di (rest home and hospital), the manager have maintained at least eight hours annually of professional development activities related to managing a rest home. |

##### **Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.2: Service Management **(**HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

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| **Attainment and Risk:** FA |
| **Evidence:** |
| During a temporary absence, the clinical manager covers the manager’s role.  D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. The operations manager also provides support in the absence of the facility manager. |

##### **Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)**

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.7: Human Resource Management **(**HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Register of RN and EN practising certificates is maintained, both at facility level and within Bupa. Website links to the professional bodies of all health professionals have been established and are available on the Bupa intranet (quality and risk / Links). There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. All staff files included a personal file checklist.  The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. Completed orientation booklets are on staff files. Staff interviewed (four caregivers, and activity therapist) were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. There are three Careerforce assessors at Riverside and all staff are encouraged to complete qualifications.   Interviews with the facility manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards and/or dementia unit standards. (Aligns with Bupa policy and procedures).  There is an annual education schedule that is being implemented. In addition, opportunistic education is provided by way of toolbox talks. A number of toolbox talks have been completed at Riverside. There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. dementia, delirium. Bupa is the first aged care provider to have a council approved PDRP. The nursing Council of NZ has approved and validated their PDRP for five years. This is a significant achievement for Bupa and their qualified nurses. Bupa takes over the responsibility for auditing their qualified nurses. All RNs at Riverside have commenced their PDRP portfolios.   Discussion with management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. 2014 training reviewed includes dementia/delirium and management of behaviours that challenge.  A competency programme is in place with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are completed annually and a record of completion is maintained - signed competency questionnaires sighted in reviewed files. Staff interviewed were aware of the requirement to complete competency training.   All RNs have current First Aid Certificates.  E4.5f: The service has employed 12 new staff including (but not limited to) five caregivers, five RNs for the new unit dementia unit. One of the new five caregivers have completed the required dementia standards. There are also six caregivers currently working in the hospital that will also be rostered in the dementia unit. All six are in the process of completing their dementia standards The facility manager advised that a RN will be rostered across 24/7 in the dementia unit. Three of the five RNs employed for the dementia unit have previous experience working in dementia units. The National Bupa dementia advisor is scheduled to complete a training session with all staff that are to work in the new unit 16 April 2014. New staff are scheduled to commence orientation prior to opening and complete orientation by July 14. |

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

The appointment of appropriate service providers to safely meet the needs of consumers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Interviews with the facility manager confirmed that the caregivers when newly employed complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their first national certificates. From this - they are then able to continue with Core Competencies Level 3 unit standards. (Aligns with Bupa policy and procedures).  E4.5f: The service has employed 12 new staff including (but not limited to) five caregivers, five RNs for the new unit dementia unit. One of the new five caregivers have completed the required dementia standards. There are also six caregivers currently working in the hospital that will also be rostered in the dementia unit. All six are in the process of completing the dementia standards. The facility manager advised that a RN will be rostered across 24/7 in the dementia unit. Three of the five RNs employed for the dementia unit have previous experience working in dementia units. The National Bupa dementia advisor is scheduled to complete a training session with all staff that are to work in the new unit 16 April 2014. New staff are scheduled to commence orientation next week. |
| **Finding:** |
| All new staff are scheduled to complete orientation next week. |
| **Corrective Action:** |
| Ensure staff commence orientation to the unit prior to occupancy and complete the induction programme as per Bupa policy |
| **Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.2.8: Service Provider Availability **(**HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The WAS (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 hours are over and above. The manager has documented a Staffing Rationale document for the dementia unit. There is a clinical manager across the facility and a facility manager. Both are registered nurses and work fulltime.  The draft roster for the new unit has included 24-hour registered nurse cover specifically in the unit. AM shift RN 0800 - 1630 2x Caregivers 0700 – 1530 and 0600 - 1130  PM shift RN 1530 -2300 2x caregivers 1530 – 2300 and 1630 - 2400  Nocte shift RN 2300 - 0700  Diversional Therapist 1100 – 1930 across seven days. |

##### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.3: Continuum of Service Delivery**

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.

#### Standard 1.3.5: Planning **(**HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The previous audit identified shortfalls in one file regarding updating the care plan following changes in health status.  Five files were reviewed including three rest home files and two hospital files.  The five care plans were overall written comprehensively and demonstrate service integration and input from allied health. Changes in health status were noted to be updated in LTCPs or STCPs utilised including (but not limited to); weight loss for one hospital resident, infection and skin tears for one rest home resident, pressure area and swallowing difficulties for one resident.  Notes by GP and allied health professionals, significant events, communication with families and notes as required by registered nurses. |

##### **Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)**

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.6: Service Delivery/Interventions **(**HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Residents' care plans are completed by the registered nurses. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. One caregiver interviewed stated that they have all the equipment referred to in care plans and necessary to provide care, including a hoist, wheelchairs, continence supplies, dressing supplies and any miscellaneous items.  The five care plans reviewed were all completed comprehensively. Short-term care plans were utilised for acute or short-term changes in health status. D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a 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. Continence management, pain assessment/management in-services and wound management in-service have been provided.  Wound assessment and wound management plans are in place including 14 skin tears, five lesions, five ulcers, one surgical wound, six pressure areas (two pressure areas residents admitted with). All included assessment and management plans. All wounds have documented evidence they have been reviewed in the timeframe stated and this is an improvement since previous audit.  The registered nurses interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. There is currently two wounds with District Nurse input. The facility has registered nurse cover 24/7 and has an ‘in service’ education programme.   Care plans are goal oriented and reviewed six monthly. During the tour of facility it was noted that all staff treated residents with respect and dignity. There is an improvement required around meeting ARC contract timeframes. |

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Wound assessment and wound management plans are in place including 14 skin tears, five lesions, five ulcers, one surgical wound, six pressure areas (two pressure areas residents admitted with). All included assessment and management plans. All wounds have documented evidence they have been reviewed in the timeframe stated and this is an improvement since previous audit.  The five care plans reviewed were all completed comprehensively. Short-term care plans were utilised for acute or short-term changes in health status. |
| **Finding:** |
| One recent hospital admission had 12 days before the care summary was completed and two months before the LTCP was completed. One rest home file identified six weeks from admission until the LTCP was completed. |
| **Corrective Action:** |
| Ensure documentation including care plans are completed within the required ARC contract timeframes. |
| **Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.12: Medicine Management **(**HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Medication management was reviewed in the rest home/ hospital. The previous audit shortfalls around controlled drug weekly checks and medication signing sheets have been addressed. 10 medication charts were reviewed. One medication chart had no dates documented by the GP on the med chart, one medication chart was a faxed copy and difficult to read. The medications are stored in a locked trolley. Controlled drugs are stored in a locked safe in the treatment room and only the registered nurses have access to controlled drugs and two people (one being an R.N) must sign controlled drugs out. Registered nurses administer medications and all have passed their competency administer medications. Medication competencies are to be completed as part of orientation for the new RNs commencing in the dementia unit (link 1.2.7.4) The medication charts have alert stickers for; a) controlled drugs, b) crushed, d) allergies, e) duplicate name. The service uses four weekly robotic packs. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.  Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies. Registered nurses are peer reviewed annually and trained in medication administration and competency checked annually. Only those staff deemed competent administer medications. Competencies include a) questionnaire, b) supervised medication round, c) competency sign off. All 'medication competent' staff are responsible for medication administration. Competency tests are done annually and also if there is a medication administration error. Competencies include (but not limited to); drug administration, controlled drugs, syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers  The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. Resident medications are reviewed by the residents’ general practitioner at least three monthly. Medication audits are completed six monthly.   In the dementia unit, there is no treatment room. Therefore, residents medication will be stored in the hospital treatment room and will be prepared and taken from there into the unit to be administered from a trolley. If medication is required during the night while only one staff member is on in the dementia unit, the hospital RN will come and administer. |

##### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

The facilitation of safe self-administration of medicines by consumers where appropriate.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| D16.5.e.i.2; 10 medication charts reviewed in the rest home/hospital identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. The medication charts have alert stickers for; a) controlled drugs, b) crushed, d) allergies, and e) duplicate name. The service uses four weekly robotic packs. Medication charts have photo ID’s. There is a signed agreement with the pharmacy. Robotic medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.  Staff sign for the administration of medications on medication sheets held with the medicines. The medication folders include a list of specimen signatures and competencies. |
| **Finding:** |
| 10 medication charts were reviewed. One medication chart had no starting dates documented by the GP for the prescribed medication on the med chart, one medication chart was a faxed copy and difficult to read. |
| **Corrective Action:** |
| Ensure medications are dated and charts are legible. |
| **Timeframe (days):** 60 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is a cleaning schedule – kitchen (056) and a national menus policy (315) which states 'summer and winter menus are of a six weekly cycle and are to be used on a weekly rotational basis and the menus are available on the intranet'.  The national menus have been audited and approved by an external dietitian, last in May 2013.  The service employs three kitchen staff including two cooks. The main kitchen supplies meals for the entire service.  All of the kitchen team at Riverside have completed food safety certs. The service has a large workable kitchen that contains 1 walk-in pantry, freezer, a walk in chiller, an air steam oven, bain marie, microwave, commercial oven and hot plates. There is a preparation area and receiving area.  Kitchen fridge, food and freezer temperatures are monitored and documented daily and daily in other areas. Resident annual satisfaction survey which includes food, there is also a post admission survey conducted after six weeks. There are a number audits completed include; a) kitchen audit, b) environment kitchen, c) catering service survey, and d) food service audit.  There is a nutrition - assessment and management policy (347) and a weight management policy (079). The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Special diets are noted on the kitchen notice board, which is able to be viewed only by kitchen staff. Special diets being catered for include soft diets, puree diets and diabetics. There is a kitchen manual that includes (but is not limited to): hand washing, delivery of goods, storage, food handling, preparation, cooking, dishwashing, waste disposal and safety.  Daily temperature checks of chiller, freezer, bain marie and dishwasher are maintained.   Advised that a hot box will be used to transfer food to the dementia unit kitchenette, which is open-plan. The kitchenette has not yet been installed and therefore safety issues such as managing boiling water could not be sited. Advised that boiling water and drinks will come from the kitchen for meals and snack / drink times, however there will be some domestic style equipment, which will always be available in the locked cupboard in the unit kitchenette (link 1.4.2.4). There is to be a fridge in the unit for the storage of snacks. |

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

## **Outcome 1.4: Safe and Appropriate Environment**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

#### Standard 1.4.1: Management Of Waste And Hazardous Substances **(**HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The service has in place a waste management policy (304) for the safe disposal of waste and hazardous substances including general and special waste. Cleaning products are stored in the locked cleaning cupboard/sluice in the facility. Material safety data sheets are available. There is a sluice in the dementia unit that is to be locked. All chemicals are clearly labelled with manufacturers labels within the facility. Sharps containers are available in the hospital and meet the hazardous substances regulations for containers.  Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. The new unit has a sluice room that is in the process of being completed (link 1.2.4). A sanitiser has been purchased for the sluice room. Gloves, aprons, and goggles are available for staff. Infection control policies state specific tasks and duties for which protective equipment is to be worn. |

##### **Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)**

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Material safety data sheets are available. There is a sluice in the dementia unit that is to be locked. All chemicals are clearly labelled with manufacturers labels within the facility. Chemical safety training is provided annually to staff. Sharps containers are available in the hospital and meet the hazardous substances regulations for containers.  Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. The new unit has a sluice room that is in the process of being completed. A sanitiser has been purchased for the sluice room. |
| **Finding:** |
| The sluice room is not yet complete or locked. |
| **Corrective Action:** |
| Ensure the sluice room is completed and chemicals are secured |
| **Timeframe (days):** Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)**

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.4.2: Facility Specifications **(**HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

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| **Attainment and Risk:** PA Moderate |
| **Evidence:** |
| The service completes environmental audits and building compliance audits. The service has renovated part of the existing rest home wing into a secure dementia unit. The unit is still in the process of being completed. There is to be a secure key padded door to the dementia unit from the reception/entrance area. There is also to be another key padded door at the other end of the resident rooms (link 1.4.7.6).  The maintenance programme ensures all buildings; plant and equipment are maintained to an appropriate standard or specification where a standard exists for example a planned maintenance system, reactive maintenance system, list of equipment requiring calibration and current calibration reports, list of external contractors and list of preferred suppliers. In the facility residents are able to bring their own possessions and are able to adorn their room as desired.  Consideration is given to residents when purchasing new furniture/equipment Relevant persons are consulted when selecting furniture, equipment, floor surface coverings. A Procurement Manager assists with ensuring appropriate purchase of equipment e.g. hoists, Air relief mattresses. The service has purchased new furniture for the dementia unit. There is a current building warrant of fitness that expires 15/12/14. A code of compliance will be obtained for the newly renovated wing. The planting/landscaping of the secure garden area is not yet completed. The deck off the lounge has not yet been completed. The doors off five resident rooms have not yet been adjusted to ensure they are impenetrable. |

##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is a current building warrant of fitness that expires 15/12/14. A CPU will be obtained for the newly renovated wing. The service completes environmental audits and building compliance audits. The service has renovated part of the existing rest home wing into a secure dementia unit. The unit is still in the process of being completed. |
| **Finding:** |
| The service has renovated part of the existing rest home wing into a secure dementia unit. The unit is still in the process of being completed. |
| **Corrective Action:** |
| Ensure a CPU is obtained for the newly renovated wing and forwarded to the DHB and HealthCERT |
| **Timeframe (days):** Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)**

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets, kitchen areas and the two resident rooms that have ensuites. The corridors are carpeted. All resident rooms and lounges are part of the existing building that has been converted to ensure its appropriateness for dementia care. This includes a dining room with an open plan kitchenette and an adjoining lounge. The nurses’ station is to be situated the dementia lounge, This is so the caregivers and trained staff can be positioned in close proximity to residents. Secure cupboards are to be installed. Windows that open to non-secure areas have opening limiters. There is a garden area that is in the process of being landscaped, including a deck off the lounge. There are five resident rooms with doors that currently open out into the rest home garden courtyard. Advised that these doors are to be decommissioned, handles removed to ensure they are impenetrable (link 1.4.7.6). Bupa has temperature monitoring – environmental hot water, and kitchen temperature policies, which guide staff on the acceptable hot water temperatures for the various areas within the facility. Hot water is monitored monthly and remains around 45 degrees. There are tempering valves installed in all resident areas. Water temperatures are yet to be checked in the new unit. |
| **Finding:** |
| a) The renovations and refurbishments to the new unit are not yet completed; b) the lounge/dining area/kitchenette has not yet completed, c) Water temperatures are yet to be checked in the new unit. |
| **Corrective Action:** |
| a) and b) Ensure the completed renovations are sited by the DHB prior to occupancy. c) Ensure water temperatures are checked to resident areas. |
| **Timeframe (days):** Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)**

Consumers are provided with safe and accessible external areas that meet their needs.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| There is an enclosed garden area with seating and shade accessible. The areas are spacious and will allow residents to wander. |
| **Finding:** |
| The planting/landscaping of the secure garden area is not yet completed. The deck off the lounge has not yet been completed. |
| **Corrective Action:** |
| Ensure the external area is completed and secure. |
| **Timeframe (days):** Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.4.3: Toilet, Shower, And Bathing Facilities **(**HDS(C)S.2008:1.4.3)

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.

ARC E3.3d ARHSS D15.3c

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The new dementia unit has one toilet off the lounge/dining area, two toilet/showers and one shower. There are five resident rooms with toilet only en-suites. Hand washing and drying facilities are within close proximity of the toilets. Communal toilets have paper towels/flowing soap for resident use. Alcohol hand gel dispensers are accessible to staff and visitors. Bathrooms are still being renovated (link 1.4.2.1). |

##### **Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)**

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.4.4: Personal Space/Bed Areas **(**HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

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| **Attainment and Risk:** FA |
| **Evidence:** |
| Resident’s rooms are large enough to manoeuvre. There is also adequate space in communal bathrooms, living area, and hallways for residents to wander around. Transfers between rooms can be managed in an ambulance stretcher if required. |

##### **Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)**

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining **(**HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There is an open-plan dining and lounge area. New furniture has been purchased. The renovations are still in the process of being completed including the installation of the kitchenette. One of the original resident rooms is in the process of being turned into quiet lounge. (link 1.4.2.1) |

##### **Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)**

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.4.6: Cleaning And Laundry Services **(**HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| There are policies including - cleaning department - use of equipment policy (051) and a cleaning schedule – nursing staff (057). There is also a cleaning schedule/methods – cleaners (053). All laundry is done on site and there are dedicated laundry and cleaning staff. There is a dirty to clean flow in the laundry. Laundry bags are used and will be used to transport laundry from the dementia unit to the laundry. Laundry services audits are completed twice a year and last done Jan 2014 (96.8%). An environmental hygiene - cleaning audit was last completed in March 2014 (75%) with corrective actions. Corrective actions required are followed through the quality/risk management and staff meetings. The laundry and cleaning room are designated areas and clearly labelled. Chemicals are stored in a locked room. All chemicals are labelled with manufacturer’s labels. There is a sluice room in the dementia unit for the disposal of soiled water or waste that is in process of being completed (link 1.4.2.1). Cleaner’s trolley and products will also be available in the sluice. The sluice room is to be locked. |

##### **Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)**

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)**

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
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| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.4.7: Essential, Emergency, And Security Systems **(**HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in fire safety March 2014. Fire evacuations are held six monthly. A fire evacuation was last held on 6 March 2013. Fire training is included as part of orientation (link 1.2.7.4). There is a comprehensive civil defence manual and emergency procedures manual in place. The civil defence kit is readily accessible in a storage cupboard this includes and up to date register of all residents’ details. There is an approved evacuation plan dated 11 July 2013. There is no required changed to the fire evacuation scheme. The RNs are all first aid trained. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. The facility is well prepared for civil emergencies and has emergency lighting and BBQ’s. A store of emergency water is kept. There is a gas BBQ for alternative heating and cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The facility has civil defence kits. Hoists have battery back and there are batteries that can be used to operate electric beds in the event of a power failure. Oxygen cylinders enable residents to switch from concentrators to cylinders in the event of a power failure and there is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies necessary to manage a pandemic. The call bell system is available in all areas and indicator panels in each area. The call bell system in the dementia unit is the Austco system and this is yet to be activated. |

##### **Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)**

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)**

Where required by legislation there is an approved evacuation plan.

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)**

Alternative energy and utility sources are available in the event of the main supplies failing.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
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| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)**

An appropriate 'call system' is available to summon assistance when required.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| The call bell system is available in all areas and indicator panels in each area. The system also connects to pages that staff carry. The call bell system in the dementia unit is the Austco system and this is yet to be activated. |
| **Finding:** |
| The call bell system in the dementia unit is the Austco system and this is yet to be activated. |
| **Corrective Action:** |
| Ensure the call bell system is fully functioning |
| **Timeframe (days):** Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)**

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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| **Attainment and Risk:** PA Low |
| **Evidence:** |
| Security policies and procedures are in place, including procedures around visitor identification. There are five resident rooms with doors that currently open out into the rest home garden courtyard. Advised that these doors are to be decommissioned, handles removed to ensure they are impenetrable |
| **Finding:** |
| There are keypad locks to be installed at the two entrance doors. The doors off five resident rooms have not yet been adjusted to ensure they cannot be used to exit the building. |
| **Corrective Action:** |
| Ensure the unit is secure |
| **Timeframe (days):** Prior to occupancy *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

#### Standard 1.4.8: Natural Light, Ventilation, And Heating **(**HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

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| --- |
| **Attainment and Risk:** FA |
| **Evidence:** |
| The unit has ceiling heaters, which can be controlled in each area/room; rooms are well ventilated and light. Facility temperatures are monitored. There is plenty of natural light in resident’s rooms. |

##### **Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)**

Areas used by consumers and service providers are ventilated and heated appropriately.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)**

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

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| **Attainment and Risk:** FA |
| **Evidence:** |
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| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.1: Infection control management **(**HDS(IPC)S.2008:3.1)

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.

ARC D5.4e ARHSS D5.4e

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| **Attainment and Risk:** FA |
| **Evidence:** |
| The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service.  The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The infection control committee includes a cross section of staff. The committee and the governing body is responsible for the development of the infection control programme and its review. The programme is reviewed annually at an organisational level. The facility has access to professional advice within the organisation and has developed close links with the G.P's, Community Laboratory, the infection control and public health departments at the local DHB. Infection control is discussed regularly in the monthly registered nurse meetings. It is also discussed in the caregiver and quality meetings. Minutes are available for staff.  There are Bupa regional infection control groups (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Communal toilets/bathrooms have hand hygiene notices in large print. There is a staff health policy. There have been no outbreaks since previous audit. |

##### **Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)**

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)**

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)**

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

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| **Attainment and Risk:** FA |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

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| **Attainment and Risk:** Not Audited |
| **Evidence:** |
|  |
| **Finding:** |
|  |
| **Corrective Action:** |
|  |
| **Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)* |