

Bupa Care Services NZ Limited - Stokeswood Rest Home & Hospital

Current Status: 30 June 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

Stokeswood is part of the Bupa group of facilities and currently provides care for up to 63 residents (43 rest home and 20 hospital). This partial provisional audit included verification of newly built 24-bed capacity hospital wing and the preparedness of the service to provide dementia level care in the old hospital wing.

The new hospital wing has 24-bed capacity and all rooms are en-suited. Stokeswood has plans to open mid July 2014. Twenty hospital residents from the current hospital wing will be transferred to the new wing. After the transfer of residents, the current hospital will be converted to a 20 bed capacity dementia wing and this upgrade is planned to be completed in two months. The facility will have a total of 87 beds (43 rest home, 24 hospital and 20 bed dementia).

The facility manager (registered nurse) has many years' experience in health and disability sector and she is supported by an experienced aged care clinical manager.

The audit identified the new facility, staff roster and equipment requirements and processes are appropriate for providing hospital and dementia level care and in meeting the needs of the residents.

There are clear procedures and responsibilities for the safe and smooth transition of residents into the new wing and Bupa is an experienced provider in delivery of hospital and dementia care services.

The corrective actions required by the service are all related to the completion of the building. As part of the provisional audit, previous corrective actions around medication management, medical review on entry to the service and care planning have also been reviewed and this audit identified that further improvements continue to be required in these areas.

HealthCERT Aged Residential Care Audit Report (version 4.2)

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

Legal entity name:	Bupa Care Services NZ Limited
Certificate name:	Bupa Care Services NZ Limited - Stokeswood Rest Home & Hospital
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Partial Provisional Audit
Premises audited:	Stokeswood Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 30 June 2014 End date: 30 June 2014
Proposed changes to current services (if any): 1) A newly built 24 bed capacity new hospital care wing. 2) Configuration of current 20 bed hospital wing into a dementia care unit.	
Total beds occupied across all premises included in the audit on the first day of the audit:	62

Audit Team

Lead Auditor	XXXXXXXXXX	Hours on site	5.75	Hours off site	3.00
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	XXXXXXXXXX			Hours	2

Sample Totals

Total audit hours on site	5.75	Total audit hours off site	5	Total audit hours	10.75
Number of residents interviewed		Number of staff interviewed	1	Number of managers interviewed	3
Number of residents' records reviewed	5	Number of staff records reviewed	7	Total number of managers (headcount)	3
Number of medication records reviewed	10	Total number of staff (headcount)		Number of relatives interviewed	
Number of residents' records reviewed using tracer methodology				Number of GPs interviewed	

Declaration

I, XXXXXXXX, 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:

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 Friday, 11 July 2014

Executive Summary of Audit

General Overview

Stokeswood is part of the Bupa group of facilities and currently provides care for up to 63 residents (43 rest home and 20 hospital).

This partial provisional audit included verification of newly built 24-bed capacity hospital wing and the preparedness of the service to provide dementia level care in the old hospital wing.

The new hospital wing has 24-bed capacity and all rooms are en-suited. Stokeswood has plans to open mid July 2014. Twenty hospital residents from the current hospital wing will be transferred to the new wing. After the transfer of residents, the current hospital will be converted to a 20 bed capacity dementia wing and this upgrade is planned to be completed in two months. The facility will have a total of 87 beds (43 rest home, 24 hospital and 20 bed dementia).

The facility manager (registered nurse) [RN] has many years' experience in health and disability sector and she is supported by an experienced aged care clinical manager.

The audit identified the new facility, staff roster and equipment requirements and processes are appropriate for providing hospital and dementia level care and in meeting the needs of the residents.

There are clear procedures and responsibilities for the safe and smooth transition of residents into the new wing and Bupa is an experienced provider in delivery of hospital and dementia care services.

The corrective actions required by the service are all related to the completion of the building.

As part of the provisional audit, previous corrective actions around medication management, medical review on entry to the service and care planning have also been reviewed and this audit identified that further improvements continue to be required in these areas.

Outcome 1.2: Organisational Management

During a temporary absence of the facility manager, the clinical manager covers the manager's role. If temporary absence is longer than two weeks, Bupa relief manager or operations manager will cover the manager's role. The operations manager provides oversight and support.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Number of caregivers have completed dementia standards and some caregivers have already started their training. Staff are encouraged to obtain dementia specific qualification. Bupa also has another facility that provides dementia level care and the facility manager stated that a pool of staff is available through the organisation. Stokeswood has a nurse educator (RN) who is employed for 7.5 hours a week.

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. Current staff will transition to the new wing and with additional four beds; a new staff will be employed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is 24 hour RN cover in the hospital. There is a plan in place to cover the dementia unit. Additional RN for the proposed wing is in progress. The dementia wing will include oversight by the clinical manager.

Outcome 1.3: Continuum of Service Delivery

Stokeswood has a new kitchen and the kitchen is well designed and equipped to manage additional food services. The chef at Stokeswood have completed food safety certificate. The facility manager advised that kitchen staff completed internal training regarding food handling. Currently meals are delivered with bain-marie and a hot box (scan box) to current hospital wing. The facility manager advised that this will continue.

There are medication management policies and procedures that align with current guidelines. The new wing has a drug room with a key pad access. Stokeswood will continue to use robotic pack dispensing system. Corrective actions required around medication management have not been addressed yet.

A registered nurse undertakes the assessments on admission and the initial support plan completed within 24 hours of admission. Long term care plans are completed within three weeks of admission. Progress notes are conscientiously recorded for all shifts and more frequent notes are entered following resident change in health needs. Therefore, required corrective actions around progress note documentation and time frame of long term care planning have been addressed. However, further improvements are required around care planning.

Outcome 1.4: Safe and Appropriate Environment

Management of waste and hazardous substances is covered during orientation of new staff and is included as part of the annual training plan. Hazard register identifies hazardous substances and the register is reviewed in 2014. Hazards related to the new building site are identified.

The new hospital wing is purpose built and is near completion. All building and plant have been built to comply with legislation. All required equipment has been purchased. Interior work has been completed and painting work is undergoing around corridors to the new wing.

External areas are in the process of being landscaped including access through the dining lounge area and around the building.

The new wing is appropriately heated and ventilated. There are ceiling heaters in resident rooms and ceiling heat pumps in hallways and common areas. There are heat control panels in individual rooms. In proposed dementia wing, has mixture of panel and ceiling heating. All rooms have window and there is plenty on natural sunlight throughout the wing.

In the new wing, all rooms are en-suited and the nurse's station looks out on the open plan dining and lounge area. Residents rooms are spacious and allow care to be provided and for the safe use and manoeuvring of mobility aids.

The proposed dementia unit has a large dining/lounge area with a small kitchen used as a servery unit. The proposed dementia wing rooms are suitable for residents requiring dementia level care.

There is a comprehensive civil defence manual and emergency procedure manual in place. Appropriate training, information, and equipment for responding to emergencies are provided. Staff training in fire safety occurs six monthly. There is at least one staff member with a current first aid certificate per shift. Call bells are available in all resident areas. Residents, staff and families continue to use the front entry to Stokeswood and no changes required for the security of the building. Improvements are required to the proposed dementia wing around security and landscaping.

The fire evacuation plan has yet to be signed off as approved by the NZ fire service and current Certificate of Public Use has not been obtained yet.

Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. There is a secure area for the storage of cleaning and laundry chemicals. Upgrade of the current laundry is in progress.

Outcome 2: Restraint Minimisation and Safe Practice

Outcome 3: Infection Prevention and Control

The infection control (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The IC policies and procedures are developed by the Bupa quality and risk team and comply with accepted good practice. The scope of the IC programme policy and IC programme description are available. There is a job description for the IC coordinator and clearly defined guidelines. IC input was obtained in design of the new wing.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	0	11	0	4	2	0	0
Criteria	0	28	0	6	4	0	0

	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	63

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(C)S.2008	Standard 1.3.3: Service Provision Requirements	Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.	PA Low			
HDS(C)S.2008	Criterion 1.3.3.3	Each stage of service provision (assessment, planning, provision, evaluation, review,	PA Low	Two of five files reviewed showed that the GP did not review the resident within 48 hours after admission. In one file GP review was	Ensure that GP review is completed within 48 hours of admission.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		and exit) is provided within time frames that safely meet the needs of the consumer.		documented a week after admission and in the second file, GP review was noted three weeks after admission.		
HDS(C)S.2008	Standard 1.3.8: Evaluation	Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low			
HDS(C)S.2008	Criterion 1.3.8.3	Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	Review of five resident files identified the following shortfalls; (i) one resident was transferred from rest home level care to hospital level care in 2012. There is an evidence of brief evaluation and entries into the rest home level care plan which indicate several changes on resident's current condition. However, two years after admission to hospital level care, full evaluation of the care plan is not completed. Required interventions are not clear and provides conflicting interventions around mobility. The evaluation sheet and the care plan had small data entered into the section concerned, but the care plan documentation consequently showed a lot of entries but not always the detail that reflected the current needs. (ii) Two files are reviewed around weight loss. In both files there were records to reflect the residents had been weighed monthly. The	(i) Ensure that resident's care needs are fully reviewed, interventions are clear and specialist input is obtained as required. (ii) Ensure that resident/s weight records are accurate.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
				<p>resident's weight fluctuated unexpectedly and a question mark was placed on the weight record, however follow up has not been completed. Discussions with clinical manager confirmed that there are two different scales in Stokeswood, one being sitting and the other one is standing scale. Discussions with the facility manager confirmed that it is recommended that the same scale is to be used to maintained accurate results. Documentation did not show which scales are to be used. Both scales are calibrated annually. (iii) A wound management plan is not being updated and has been continued with same wound care plan over a five months and a specialist input has not been obtained.</p>		
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 Moderate			
HDS(C)S.2008	Criterion 1.3.12.1	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration,	PA Moderate	10 medication charts from the current hospital wing are reviewed. The following shortfalls are identified; a) one resident had lactulose charted twice a day but in five occasions, it has been given once a day. The	a) to e) Ensure medications are administered and documented as prescribed.	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		reason for not administering the prescribed dose is not documented. b) one resident had lactulose charted once daily but in five occasions, the daily dose was not given. The reason for not administering the prescribed dose is not documented. c) one resident was prescribed pamol four times daily. Throughout the month of June, it had administered irregularly such as twice a day in three occasions, three times daily in six occasions and once daily in two occasions. d) Morphine 10 mg charted twice a day and in one occasion, it is counted out of the controlled drug register but it is not signed as administered in the medication signing sheet and e) Prednisone and Augmentin prescribed on 25 of June for one resident. Although Augmentin is administered on the next day, the first dose of prednisone had not been documented as administered until 27 of June. Then the next dose was signed on 30 of June. This is discussed with the RN who is unable to explain this discrepancy.		
HDS(C)S.2008	Standard 1.4.2: Facility Specifications	Consumers are provided with an appropriate, accessible physical environment and	PA Moderate			

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		facilities that are fit for their purpose.				
HDS(C)S.2008	Criterion 1.4.2.1	All buildings, plant, and equipment comply with legislation.	PA Moderate	(i) The building certificate for public use is yet to be obtained (ii) Hot water monitoring has not been completed yet in the new wing. (iii) Current building warrant of witness expired on 30 June 2014.	(i) A Certificate of Public Use (CPU) must be sighted by DHB/healthcert prior to opening of the new hospital wing. (ii) Ensure that hot water temperature in the hospital wing is safe at the tap and meet regulations. (iii) Ensure that the building current warrant of fitness is obtained as soon as possible (sighted expires 30 June 2015). (vi) Ensure that a CPU is obtained prior to opening of the dementia wing.	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	(i) The work for the proposed dementia unit has not started yet, therefore the existing building has not been converted to ensure its appropriateness for dementia care. This includes a dining room with a kitchenette and an adjoining lounge. (ii) Some of the windows in the proposed dementia unit have no opening limiters.	(i) Ensure that safety measures are implemented in design of the kitchenette /dining/lounge area in the proposed dementia unit. (ii) Windows that open to non-secure areas have opening limiters in the proposed dementia unit prior to opening.	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 Moderate	Landscaping is in the process of being completed for the new hospital wing and the work has not started for proposed dementia wing yet. In the new wing, exit to the outside areas has ramps that require railing.	(i) Ensure landscaping is completed in areas that residents access prior to occupancy of the hospital wing, (ii) Ensure that railing is completed around ramps prior to opening of the hospital wing, (iii) Ensure that landscaping is completed and external areas are safe prior opening of the dementia	Prior to occupancy

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
					wing.	
HDS(C)S.2008	Standard 1.4.6: Cleaning And Laundry Services	Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Low			
HDS(C)S.2008	Criterion 1.4.6.3	Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.	PA Low	A small section of the current laundry is under construction to accommodate additional services. The facility manager stated that a commercial washing machine and a commercial dryer will be added to the new laundry. She also stated that there is some communication around the laundry services to be shut down for six weeks to accommodate the upgrade. However on the day of the audit, discussions with the manager confirmed that management of laundry services during this period was not clear.	Ensure that the laundry is large enough for the increase in dirty laundry prior to occupancy of the dementia wing. Ensure that clear procedures are in place if the laundry is shut down for a period of time.	90
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 1.4.7.1	Service providers receive appropriate information, training, and equipment to respond to identified emergency and	PA Low	Staff training in fire safety and fire drill are scheduled for 8 July 2014.	(i)Ensure that staff training in fire safety and fire drill is completed prior to opening of the hospital wing. (ii) Ensure that staff training in fire safety and fire drills is completed	Prior to occupancy

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		security situations. This shall include fire safety and emergency procedures.			prior opening of the dementia wing.	
HDS(C)S.2008	Criterion 1.4.7.3	Where required by legislation there is an approved evacuation plan.	PA Low	The fire evacuation plan has yet to be signed off as approved by the NZ fire service.	(i)Ensure an approval letter has been obtained from the Fire Service to cover both the hospital wing and the renovated dementia unit.	90
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 Moderate	The proposed wing provides hospital level care therefore external garden area is not secured and secure doors on entry to the service has not been placed yet.	Ensure that external areas and entry to the proposed wing is secured prior to opening.	Prior to occupancy

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

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

Attainment and Risk: FA

Evidence:

Stokeswood is part of the Bupa group of facilities and provides care for up to 63 residents (43 rest home and 20 hospital). On the day of audit, there were 42 rest home and 20 hospital residents.

The new hospital wing has 24-bed capacity and the current hospital will be converted to a 20 bed capacity dementia wing on transfer of hospital residents to the new wing. The new wing is near completion and 20 hospital residents will be transferred to the new wing. Stokeswood has plans to open the new hospital wing by mid-July. The dementia wing was originally planned to open by December, however the facility manager advised that, after transition of residents to the new wing, the work will start and it is planned to be completed in two months. This will bring the total capacity to 87 beds (43 rest home, 24 hospital and 20 bed dementia).

Bupa's overall vision is "Taking care of the lives in our hands". There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes are implemented at Stokeswood. 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 Health & Disability Commission (HDC) reports (learning's from other provider complaints) are also tabled at this forum. Senior members of the quality and risk team are also members of the Bupa Market Unit, Australia/New Zealand Clinical Governance committee who meet two monthly.

Provision of dementia care services is new to Stokeswood; however Bupa dementia care advisor is available for support and training. Across Bupa, four benchmarking groups are established for rest home, hospital, dementia, and 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.

Stokeswood is managed by an experienced management team. The facility manager (RN) is an experienced registered nurse who has been in this role over three years. She has a background in Gerontology and Disability. She is supported by an experienced clinical manager who has been in the position for six years. Support is also provided by the operations manager who visits at least once each month.

There are job descriptions for all management positions that include responsibilities and accountabilities.

ARC, D17.4b (hospital), the facility manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

ARC E2.1, The philosophy of the organisation and service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.

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.

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 1.2.1.3 (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.

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.)*

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

Attainment and Risk: FA

Evidence:

During a temporary absence of the facility manager, the clinical manager covers the manager's role. If temporary absence is longer than two weeks Bupa relief manager or operations manager will cover the manager's role. The operations manager provides oversight and support.

D19.1a; A review of the documentation, policies and procedures and discussions with management identified that the service operational management strategies, quality improvement programme, which includes culturally appropriate care, minimises risk of unwanted events and enhances quality.

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.

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.)

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

Attainment and Risk: FA

Evidence:

Stokeswood employs 11 registered nurses and one enrolled nurse. Register of RN and Enrolled Nurse practising certificates are maintained. 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. Seven staff files reviewed (one clinical manager, two registered nurses, two kitchen staff and two caregivers) confirmed that human resource policies are implemented and performance appraisals are up to date. Stokeswood have sufficient human resources to manage transition to the new wing.

Operations manager advised that the Bupa dementia advisor will undertake two compulsory training sessions with all staff as an introduction to dementia before opening. Dementia and challenging behaviour training is offered to staff as part of the annual training programme directed by head office. Facility manager advised all caregivers are encouraged to complete the required dementia standards with career force.

D17.7d: RN competencies include; assessment tools, BSLs/Insulin admin, Controlled drug (CD) administration, moving & handling, nebuliser, oxygen admin, PEG tube care/feeds, restraint, wound management, CPR, and T34 syringe driver.

ARC E4.5f. To date Stokeswood already have four caregivers who completed dementia standards and seven caregivers have already started their training. The facility manager stated that two of those will obtain their qualification in two months and five of them by December 2014. She advised that they will be rostered in the dementia wing. The orientation booklet programme aligns with foundation skills unit standards. On completion of this orientation staff have effectively attained their first national certificates.

Staff are encouraged to obtain dementia specific qualification. Bupa also have another facility within the region that provide dementia level care and the facility manager stated that a pool of staff is available through the organisation.
Stokeswood has a nurse educator (RN) who is employed for 7.5 hours a week.

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.

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

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.

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

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.

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 1.2.7.5 (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.

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.)*

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

Attainment and Risk: FA

Evidence:

There is an organisational staffing policy (359) that aligns with contractual requirements and includes skill mixes. The organizations '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.

Discussions with the management team confirms that current staff will transition to the new wing and with additional four beds; a new staff will be employed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is 24 hour RN cover in the hospital.

There is a plan in place to cover the dementia unit. Additional RN for the proposed dementia wing is in progress. Activity hours will be shared across the facility until resident numbers increase. The dementia wing will include oversight by the clinical manager. Discussions with the management team confirmed that initially staff who completed dementia qualifications will be rostered for the dementia wing and the agency staffing will be utilised as needed. For the proposed dementia unit, the draft roster is as follows:

RN- 16 Hours a week.-06-45- 3.15pm

Caregiver- 1x 7am-3pm, 1x 7.30-2.30, and 1x8am-1.30pm

Pm- 1x3-11.15pm, 1x2.30-7.30pm, 1x5.30-11pm

Nocte -2x 11-7pm

Activities coordinator-1x2.30- 6.30pm.

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.

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.)*

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 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: PA Low

Evidence:

A registered nurse undertakes the assessments on admission and the initial support plan is completed within 24 hours of admission and long term care plans are completed within three weeks of admission. Progress notes are conscientiously recorded for all shifts and more frequent notes are entered following resident change in health needs. Therefore, required corrective actions around progress notes documentation and time frame of long term care planning have been addressed. However, an improvement is required around a medical review by GP on entry to the service.

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: PA Low

Evidence:

A registered nurse undertakes the assessments on admission and the initial support plan is completed within 24 hours of admission. Five files (hospital level) are reviewed. All five files showed that long term care plans are completed within three weeks of admission.

Finding:

Two of five files reviewed showed that the GP did not review the resident within 48 hours after admission. In one file GP review was documented a week after admission and in the second file, GP review was noted three weeks after admission.

Corrective Action:

Ensure that GP review is completed within 48 hours of admission.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

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.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: PA Low

Evidence:

Care plans are reviewed and evaluated by the registered nurses. There is at least a one- three monthly review by the GP. There are short term care plans to focus on acute and short-term issues. Two of the five files sampled included short term care planning around wound care and infection.

Stokeswood have addressed shortfalls from their previous audit around; a) wound care is included in the long term care planning, b) de-escalation techniques are documented in the long term care planning as appropriate, c) a resident with infection had up to date care planning that describes infection prevention and control techniques, d) a resident with type2 diabetes also had risk management plan around insulin management of type2 diabetes and e) neurological observations are completed as required following a fall incident. However, further improvements were identified this audit around care planning.

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: PA Low

Evidence:

Care plans are reviewed and evaluated by the registered nurses. There is at least a one- three monthly review by the medical practitioner. There are short term care plans to focus on acute and short-term issues. Two of the five files sampled included short term care planning around wound care and infection.

Finding:

Review of five resident files identified the following shortfalls; (i) one resident was transferred from rest home level care to hospital level care in 2012. There is an evidence of brief evaluation and entries into the rest home level care plan which indicate several changes on resident's current condition. However, two years after admission to hospital level care, full evaluation of the care plan is not completed. Required interventions are not clear and provides conflicting interventions around mobility. The evaluation sheet and the care plan had small data entered into the section concerned, but the care plan documentation consequently showed a lot of entries but not always the detail that reflected the current needs. (ii) Two files are reviewed around weight loss. In both files there were records to reflect the residents had been weighed monthly. The resident's weight fluctuated unexpectedly and a question mark was placed on the weight record, however follow up has not been completed. Discussions with clinical manager confirmed that there are two different scales in Stokeswood, one being sitting and the other one is standing scale. Discussions with the facility manager confirmed that it is recommended that the same scale is to be used to maintained accurate results. Documentation did not show which scales are to be used. Both scales are calibrated

annually. (iii) A wound management plan is not being updated and has been continued with same wound care plan over a five months and a specialist input has not been obtained.

Corrective Action:

(i) Ensure that resident's care needs are fully reviewed, interventions are clear and specialist input is obtained as required. (ii) Ensure that resident/s weight records are accurate.

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

Attainment and Risk: PA Moderate

Evidence:

There are medication management policies and procedures that align with current guidelines. The new wing has a medication room with a key pad access. Stokeswood will continue to use robotic pack dispensing system.

A Medication - Self-Administration Policy is available if required. The Bupa policies identify that medication errors are treated as an incident and captured as part of the incident management system including benchmarking.

Controlled drugs are stored in a locked safe in the treatment room in the current hospital wing. Only the registered nurses have access to controlled drugs. Controlled drugs are recorded and checked by two staff members in the controlled drug register. The controlled drug register is well kept and aligns with legislative requirements.

Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. Facility manager stated that the controlled drug safe will be transferred to the new wing. All controlled drugs will be managed from than area.

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 pharmacy.

Currently there are no residents self-administering at Stokeswood. Medication profiles are legible, up to date and reviewed at least three monthly by the GP.

The previous certification shortfall around documentation remains an area for improvement.

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.

Attainment and Risk: PA Moderate

Evidence:

The RN advised that there are no residents prescribed with an inhaler. Two of 10 medications charts included insulin prescription. These were administered as prescribed and the signing sheets are completed /signed as administered.

Finding:

Ten medication charts from the current hospital wing are reviewed. The following shortfalls are identified; a) one resident had lactulose charted twice a day but in five occasions, it has been given once a day. The reason for not administering the prescribed dose is not documented.

Corrective Action:

a) to e) Ensure medications are administered and documented as prescribed.

Timeframe (days): 90 (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.

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 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

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

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 1.3.12.6 (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.

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.)

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

Attainment and Risk: FA

Evidence:

Stokeswood has a new kitchen and is powered by natural gas and electricity. Fittings include (but is not limited to); a) a combi oven, b) a gas hot plate, c) a commercial dishwasher, d) refrigerator and e) freezer. The kitchen has a food preparation area and benches are all stainless steel. Kitchen fridge, food and freezer temperatures are monitored and documented daily and cleaning schedule is completed daily.

Currently meals are delivered with bain-marie and a hot box (scan box) to current hospital wing. The manager advised that this will continue.

The kitchen is well designed and equipped to manage additional food services. The chef at Stokeswood have completed food safety certificate. The facility manager advised that kitchen staff have completed internal training regarding food handling.

Stokeswood has six weekly rotating summer and winter menus. 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. Changes to residents' dietary needs are communicated to the kitchen as reported by the chef.

Special diets are noted on the kitchen notice board and special diets being catered for include soft diets, puree diets and diabetics.

The dementia unit kitchenette is yet to be completed (link 1.4.2.4)

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.

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 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

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

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 1.3.13.5 (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.

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.)*

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

Attainment and Risk: FA

Evidence:

There are policies on the following:- waste disposal policy. - Medical, sharps and food waste and guidelines as well as the removal of waste bins and waste identification. There is a procedure for disposal of sharps containers. Management of waste and hazardous substances is covered during orientation of new staff and is included as part of the annual training plan. There are documented policies, procedures and an emergency plan to respond to significant waste or hazardous substance management. Accidental needle stick, blood or body fluid exposure risk assessment guidelines. All accidents/incidents are reported on the accident report form which is in turn investigated by the facility manager and reported to the Bupa Health and Safety Coordinator. Material safety data sheets are available for staff. The new wing has a sluice room with a sanitizer. Chemicals are not transferred to the new wing yet but in the proposed dementia wing, all chemicals are clearly labelled with manufacturer's labels. Advised that a sharps container will be kept in the treatment room in the new wing and this sighted in the proposed dementia wing treatment room. Hazard register identifies hazardous substances and hazard register is reviewed in 2014. Hazards related to the new building site is identified and displayed on entrance of the facility. Gloves, aprons and goggles are available for staff.

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.

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 1.4.1.6 (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.

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.)

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

Attainment and Risk: PA Moderate

Evidence:

The new hospital wing is purpose built and all building and plant have been built to comply with legislation. The facility manager stated that all required equipment has been purchased. There is a chattel list developed and approved by head office for all new equipment (including medical equipment) for the new wing. On the day of audit, comfort chairs for each room and bed side cabinets are delivered.

The nurse's station look out on the open plan dining and lounge areas, which ensures that staff are in close contact with residents even when attending to paper work or meetings. Residents are able to bring their own possessions into the home and are able to adorn their room as desired. This is evident in the current hospital wing.

There are handrails in en-suites and hallways. All rooms and communal areas allow for safe use of mobility equipment. The facility has carpet throughout with vinyl surfaces in bathrooms/toilets and kitchen areas. There is adequate space for storage of mobility equipment.

The maintenance schedule includes checking of equipment. All electrical equipment and other machinery are checked as part of the annual maintenance and verification checks with the call bell system.

The management team has not been able to access to the new wing until the audit day. Therefore checking of equipment, hot water temperatures have not been completed yet. The building certificate for public use has not been signed and landscaping has not been completed yet.

The work for the proposed dementia unit has not started yet, therefore the existing building has not been converted to ensure its appropriateness for dementia care.

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

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: PA Moderate

Evidence:

The site tour of the building confirms that the new wing is purpose built and is near completion. Interior work has been completed and painting work is undergoing around corridors proceeding to the new wing. Hot water monitoring has not been completed yet.

Finding:

(i) The building certificate for public use is yet to be obtained (ii) Hot water monitoring has not been completed yet in the new wing. (iii) Current building warrant of fitness expired on 30 June 2014.

Corrective Action:

(i) A Certificate of Public Use (CPU) must be sighted by DHB/Healthcert prior to opening of the new hospital wing. (ii) Ensure that hot water temperature in the hospital wing is safe at the tap and meet regulations. (iii) Ensure that the building current warrant of fitness is obtained as soon as possible (sighted expires 30 June 2015). (vi) Ensure that a CPU is obtained prior to opening of the dementia wing.

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.

Attainment and Risk: PA Low

Evidence:

In the new wing, the living areas are carpeted and vinyl surfaces exist in bathrooms/toilets and kitchen/dining areas. The corridors are carpeted and there are hand rails.

Finding:

(i) The work for the proposed dementia unit has not started yet, therefore the existing building has not been converted to ensure its appropriateness for dementia care. This includes a dining room with a kitchenette and an adjoining lounge. (ii) Some of the windows in the proposed dementia unit have no opening limiters.

Corrective Action:

(i) Ensure that safety measures are implemented in design of the kitchenette /dining/lounge area in the proposed dementia unit. (ii) Windows that open to non-secure areas have opening limiters in the proposed dementia unit prior to opening.

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.

Attainment and Risk: PA Moderate

Evidence:

External areas are in the process of being landscaped including access through the dining lounge area and around the building. Landscaping also required for the proposed dementia wing. This work has not started yet.

Finding:

Landscaping is in the process of being completed for the new hospital wing and the work has not started for proposed dementia wing yet. In the new wing, exit to the outside areas has ramps that require railing.

Corrective Action:

(i) Ensure landscaping is completed in areas that residents access prior to occupancy of the hospital wing, (ii) Ensure that railing is completed around ramps prior to opening of the hospital wing, (iii) Ensure that landscaping is completed and external areas are safe prior opening of the dementia wing.

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

Attainment and Risk: FA

Evidence:

There are adequate numbers of toilets and showers with access to a hand basin and paper towels. Each resident room has an en-suite which allows for the use of mobility equipment.

There are two mobility bathrooms for residents requiring a bed bath. There is also a toilet with disability access near the communal area.

The proposed dementia wing has hand basins in each room and three shared bathroom /toilet facilities.

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.

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.)*

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

Attainment and Risk: FA

Evidence:

Residents rooms are spacious and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites. The open plan lounge/dining area is large enough to accommodate mobility devices. There are also mobility bays in the hospital wing to place mobility devices without creating clutter. Residents requiring transportation between rooms or services are able to be moved from their room either by trolley, bed, lazy boy or wheelchair. The proposed dementia wing rooms are already providing hospital level care and are suitable for residents requiring dementia level care.

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.

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.)*

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

Attainment and Risk: FA

Evidence:

There is a large open plan lounge/dining area with kitchenette that can accommodate 24 residents. The nursing station is located next to the dining /lounge area with a glass window ensuring that staff are close contact with residents.

The proposed dementia unit has large dining/lounge area with a small kitchen used as a servery unit. Renovations are planned for this area (link 1.4.2.4)

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.

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.)*

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

Attainment and Risk: PA Low

Evidence:

There are laundry and cleaning policies and procedures. Laundry and cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. The service has completed internal audits of its laundry and cleaning services. There is a secure area for the storage of cleaning and laundry chemicals. All chemicals are labelled. Material safety data sheets are available for staff. Personal protective equipment are available. Current laundry is under construction.

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.

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 1.4.6.3 (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.

Attainment and Risk: PA Low

Evidence:

There is a secure sluice room in the new wing with a sanitizer. The proposed dementia wing already have a sluice room for the disposal of soiled water or waste.

Finding:

A small section of the current laundry is under construction to accommodate additional services. The facility manager stated that a commercial washing machine and a commercial dryer will be added to the new laundry. She also stated that there is some communication around the laundry services to be shut down for six weeks to accommodate the upgrade. However on the day of the audit, discussions with the manager confirmed that management of laundry services during this period was not clear.

Corrective Action:

Ensure that the laundry is large enough for the increase in dirty laundry prior to occupancy of the dementia wing. Ensure that clear procedures are in place if the laundry is shut down for a period of time.

Timeframe (days): 90 (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

Attainment and Risk: PA Low

Evidence:

There is a comprehensive civil defence manual and emergency procedure manual in place. There is emergency lighting and alternative cooking facilities are available. There is a store cupboard of supplies necessary to manage a pandemic.

Appropriate training, information, and equipment for responding to emergencies are provided. The facility manager stated that there are large water tanks available in the ceiling space. Staff training in fire safety occurs six monthly and the last completed in 4 February 2014. Staff training in fire safety and fire drill are scheduled in regards to the new wing 8 July 2014. There is at least one staff member with a current first aid certificate per shift. Call bells are available in all resident areas that is, bedrooms, en-suite toilet/showers, communal toilets, dining/rooms.

Residents, staff and families continue to use the front entry to Stokeswood and there are no changes required for the security of the building. However the proposed dementia wing do not have security doors in place and garden area is not secured yet.

The fire evacuation plan has yet to be signed off as approved by the NZ fire service.

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.

Attainment and Risk: PA Low

Evidence:

Appropriate training, information, and equipment for responding to emergencies are provided at induction and as part of the annual training programme.

Finding:

Staff training in fire safety and fire drill are scheduled for 8 July 2014.

Corrective Action:

(i) Ensure that staff training in fire safety and fire drill is completed prior to opening of the hospital wing. (ii) Ensure that staff training in fire safety and fire drills is completed prior opening of the dementia wing.

Timeframe (days): Prior to occupancy (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

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

Where required by legislation there is an approved evacuation plan.

Attainment and Risk: PA Low

Evidence:

Smoke alarms, sprinkler system and exit signs are in place in the building. The fire evacuation plan has yet to be signed off as approved by the NZ fire service.

Finding:

The fire evacuation plan has yet to be signed off as approved by the NZ fire service.

Corrective Action:

(i)Ensure an approval letter has been obtained from the Fire Service to cover both the hospital wing and the renovated dementia unit.

Timeframe (days): 90 (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.

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 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

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

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 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

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

Attainment and Risk: PA Moderate

Evidence:

The proposed dementia unit has external areas that can be secured and there is plan where the secure doors to be placed on entry to the service.

Finding:

The proposed wing provides hospital level care therefore external garden area is not secured and secure doors on entry to the service has not been placed yet.

Corrective Action:

Ensure that external areas and entry to the proposed wing is secured prior to opening.

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

Attainment and Risk: FA

Evidence:

The new wing is appropriately heated and ventilated. There are ceiling heaters in resident rooms and ceiling heat pumps in hallways and common areas. There is heat control panels in individual rooms. There is plenty of natural light in the new rooms and all rooms have windows.

In proposed dementia wing, has mixture of panel and ceiling heating. All rooms have window and there is plenty on natural sunlight throughout the wing.

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.

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 1.4.8.2 (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.

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.)*

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

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 infection control policies and procedures are developed by the Bupa quality and risk team and comply with accepted good practice. The scope of the infection control programme policy and the programme description are available. There is a job description for the infection control coordinator and clearly defined guidelines. The operations manager stated that infection control input was obtained in design of the new wing.

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.

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.

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.

Attainment and Risk: FA

Evidence:

Finding:

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.

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.)*