# Bupa Care Services NZ Limited - Cashmere View Rest Home & Hospital

## Current Status: 4 August 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 Cashmere View is part of the Bupa group of facilities. The facility is closing Ashgrove House, the current 54 bed rest home which is not viable for repair following earthquake damage and has built a new 29 bed rest home wing. There are also 54 hospital beds over two units with 53 current residents and a 20 bed psychogeriatric unit with full occupancy. There are currently 39 residents in Ashgrove House, six of whom are on respite care. Twenty nine of the permanent residents will be transferred to the new facility. Four are being reassessed and will be moving to a different level of care. The service has plans to open the new wing on 15 September 2014.

Cashmere View is managed by an experienced aged care management team. The facility manager (registered nurse) has many years of experience managing aged care facilities and has been in the role for two years. The facility manager is supported by a clinical manager who has previous aged care management and clinical management experience. The current rest home unit coordinator who is an experienced registered nurse will be the unit coordinator for the new wing.

The audit identified the new facility, staff roster and equipment requirements and processes are appropriate for providing rest home 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.

The corrective actions required by the service are around the code of compliance, the approved evacuation scheme and operational call bells. Additionally improvement is required around care planning and aspects of medication documentation.

# 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 - Cashmere View Rest Home & Hospital |

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

|  |  |
| --- | --- |
| **Types of audit:** | Partial Provisional Audit |
| **Premises audited:** | Cashmere View Rest Home and Hospital (incorporating Ashgrove House) |
| **Services audited:** | Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** |  | **End date:** | 4 August 2014 |

**Proposed changes to current services (if any):**

The service is closing the 54 bed rest home facility due to earthquake damage and opening a new 29 bed rest home unit attached to the main facility.

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

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXX | **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** | XXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 4 | Total audit hours off site | 4 | Total audit hours | 8 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed |  | Number of staff interviewed | 2 | Number of managers interviewed | 1 |
| Number of residents’ records reviewed | 8 | Number of staff records reviewed | 5 | Total number of managers (headcount) | 1 |
| Number of medication records reviewed | 14 | Total number of staff (headcount) | 97 | 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 Tuesday, 19 August 2014

## **Executive Summary of Audit**

**General Overview**

Bupa Cashmere View is part of the Bupa group of facilities. The facility is closing Ashgrove House, the current 54 bed rest home which is not viable for repair following earthquake damage and has built a new 29 bed rest home wing. There are also 54 hospital beds over two units with 53 current residents and a 20 bed psychogeriatric unit with full occupancy. There are currently 39 residents in Ashgrove House, six of whom are on respite care. Twenty nine of the permanent residents will be transferred to the new facility. Four are being reassessed and will be moving to a different level of care. The service has plans to open the new wing on 15 September 2014.
Cashmere View is managed by an experienced aged care management team. The facility manager (registered nurse) has many years of experience managing aged care facilities and has been in the role for two years. The facility manager is supported by a clinical manager who has previous aged care management and clinical management experience. The current rest home unit coordinator who is an experienced registered nurse will be the unit coordinator for the new wing.
The audit identified the new facility, staff roster and equipment requirements and processes are appropriate for providing rest home 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.
The corrective actions required by the service are around the code of compliance, the approved evacuation scheme and operational call bells. Additionally improvement is required around care planning and aspects of medication documentation.

**Outcome 1.2: Organisational Management**

Cashmere View is managed by an experienced aged care management team. The facility manager (registered nurse) has many years of experience managing aged care facilities and has been in the role for two years. The facility manager is supported by a clinical manager who has previous aged care management and clinical management experience. The current rest home unit coordinator who is an experienced registered nurse will be the unit coordinator for the new wing.
The service is currently has existing contracts for podiatrist, dietitian, physiotherapy and GP services which will continue. The newly built wing has been designed with input from evidence based practice models, resident and staff consultation, experiential evidence from the global Bupa Care Homes team, and from evaluation and identified improvements from previous Bupa NZ developments.

There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. The service has a comprehensive orientation programme 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. Staff files sampled show adherence with best human resource practices and all have completed a role specific orientation. Existing rest home staff will staff the new wing.
There is an annual education schedule that is being implemented. In addition opportunistic education is to be provided by way of tool box talks. There is a registered nurses (RN) training day provided through Bupa that covers clinical aspects of care - e.g. Dementia, Delirium. A draft staffing roster is in place for the new wing as there are less residents than the current rest home.

**Outcome 1.3: Continuum of Service Delivery**

The previous audit identified issues around short term and long term care plans. A review of files across the three service levels show that short term care plans are now well used. There continues to be improvement required around long term care plans.

The organisations medication policy and procedures follow recognised standards and guidelines for safe medicine management practice in accord with the guideline: Safe Management of Medicines.
The service uses four weekly robotic packs and has a contract with a pharmacy in Christchurch. There is a treatment room in the new wing which requires securing prior to opening. One of the two medication trolleys being used at Ashgrove House will be moved to the new wing. There is a controlled drug (CD) safe in the treatment room of one of the hospital wings that covers the two hospital and the psychogeriatric wing. There is a secure controlled drug cupboard in the new wing. The medication fridge from Ashgrove House will be moved to the new wing when the wing opens. All staff who administer medications have current medication competency assessments. There are improvements required around medication documentation.
The national menus have been audited and approved by an external dietitian. The existing kitchen has been catering for Ashgrove House and is well able to meet the needs of the lesser number of rest home residents to be in the new wing. There is kitchen staff; all of whom have completed food safety certificates. The large spacious kitchen included freezers, a chiller and walk-in pantry.
The new rest home wing has a kitchenette that has a servery out to the dining areas. This includes a servery area, fridge and dishwasher. The existing bain marie will be used to transport the food from the main kitchen to the kitchenettes in the new wing.

**Outcome 1.4: Safe and Appropriate Environment**

The new rest home wing is purpose built and is spacious. All building and plant have been built to comply with legislation. Fifteen new electric beds have been purchased and all other equipment is currently available in Ashgrove House including a hoist and will be moved to the new wing when the residents transfer.
There are centrally located nurse station’s that looks onto the lounge and ensures that staff are in close contact with residents even when attending to paper work or meetings.
Material safety data sheets are available in the laundry and the sluice in the new wing. The sluice has a sanitizer. All chemicals are clearly labelled with manufacturers labels. Gloves, aprons and goggles are available for staff. The existing cleaning and laundry services will continue to cater for the reduced number of residents.
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 in each wing for storage of mobility equipment.

All 29 rooms are single rooms, 14 with shared en-suites and 15 with single en-suites. All en-suites are large and able to cater for residents needing support and equipment. Shared en-suites have a locking system whereby when one door is locked or unlocked the other door to the en-suite automatically locks/unlocks. These can be opened if necessary by staff in an emergency. Additionally there is a communal disabled toilet and a second visitor’s toilet.
There is adequate space throughout the wing for storage of mobility equipment. There is an external courtyard/garden area. There are external walkway and gardens around the outside of the new wing. Landscaping is in the process of being completed. There is a large open plan lounge/dining area in the new wing wings. There is also a small quiet room in the nearby hospital unit.
Appropriate training, information, and equipment for responding to emergencies is provided at induction and as part of the annual training programme. The call bell system is available in all areas with visual display panels. Call bells are available in all resident areas, including (but not limited to); bedrooms, en-suite toilet/showers, communal toilets, and dining/rooms. The call bell system will also be connected to staff pages.
The new unit is appropriately heated and ventilated. There are ceiling heaters in resident rooms and ceiling heat pumps in hallways.

Improvements are required prior to occupancy around having the call bell system operational and obtaining a code of compliance. Additionally the updated evacuation scheme need to be approved by the New Zealand Fire Service.

**Outcome 3: Infection Prevention and Control**

The IC programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the IC programme policy and IC programme description is documented. There is a job description for the IC coordinator and clearly defined guidelines. The Infection Control programme links to the Quality and Risk Management system. The programme is reviewed annually at an organisational level.
The service has monthly quality/ IC meetings. Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The IC coordinator attends the southern meeting. The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 12 | 0 | 2 | 2 | 0 | 0 |
| **Criteria** | 0 | 31 | 0 | 3 | 2 | 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 | 34 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 65 |

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

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| 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 Moderate |  |  |  |
| 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 Moderate | 1) a rest home resident who does not have COPD or the use of walking frame in the care plan and for who the evaluation includes the use of continence products but this has not been transferred to the care plan, 2) a psychogeriatric resident receiving thickened fluids and a mouli diet but the care plans states normal diet, 3) a hospital resident with XXXX. A sensor mat and pain that are not addressed in the care plan, and 4) a hospital resident where XXXXX are documented in the care plan but there are no corresponding interventions (the plan has not been completed) and XXXXXXX that are not included in the care plan.  | Ensure care plans include interventions for all identified areas of need. | 60 |
| 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, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | (i) Four of 14 medication charts sampled identify the non-packaged regular medications are not always signed as administered. (ii) One resident in the psychogeriatric unit has polytears prescribed and being administers but the prescription does not document how many drops are to be administered or how often. (iii) Four of fourteen charts sampled (three in Pioneer and one in the psychogeriatric unit) have anxiolytics or antipsychotic medications charted PRN with no indication for use. (iv) The treatment room in the new wing is not yet secure.  | (i) Ensure medications are administered as prescribed. (ii) Ensure all prescriptions document the dose and frequency. (iii) Ensure PRN medications document an indication for use. (iv) Secure the treatment room in the new wing prior to opening. | 60 |
| 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 Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.4.2.1 | All buildings, plant, and equipment comply with legislation. | PA Low | A code of compliance has not yet been obtained for the new wing.  | Ensure a code of compliance is obtained and provided to the DHB. | 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 1.4.7.3 | 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 fire service. | Ensure the updated evacuation scheme is signed off by the Fire service. | 30 |
| 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 is yet to be connected.  | Ensure the call bell system is operational. | 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:**

Bupa Cashmere View is part of the Bupa group of facilities. The facility is closing Ashgrove House, the current 54 bed rest home which is not viable for repair following earthquake damage and has built a new 29 bed rest home wing. There are also 54 hospital beds over two units with 53 current residents and a 20 bed psychogeriatric unit with full occupancy. There are currently 39 residents in Ashgrove House, six of whom are on respite care. Twenty-nine of the permanent residents will be transferred to the new facility. Four are being reassessed and will be moving to a different level of care.
The service has plans to open the new wing on 15 September 2014.
The audit identified the new facility, staff roster and equipment requirements and processes are appropriate for providing rest home level care and in meeting the needs of the residents.

Bupa's overall vision is "Taking care of the lives in our hands". There are six key values that are to be displayed on the entrance wall as per Bupa processes.
There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Cashmere View has set a number of quality goals that include the opening of the new wing.

Standardised policy and procedure, annual education programme, core competency assessments and orientation programmes are implemented at all sites including Cashmere View. Bupa has robust quality and risk management systems implemented at Cashmere View. 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.
Bupa has robust quality and risk management systems implemented at Cashmere View. 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 has been in place since January 2010. Cashmere View is benchmarked for rest home, hospital and psychogeriatric care. Benchmarking results drive improvements in practice.

Cashmere View is managed by an experienced aged care management team. The facility manager (registered nurse) has many years’ experience managing aged care facilities and has been in the role for two years. The facility manager is supported by a clinical manager who has previous aged care management and clinical management experience. The current rest home unit coordinator who is an experienced registered nurse will be the unit coordinator for the new wing. The management team is supported by the Operations Manager oversees ten sites as part of the Southern one region. She visits regularly during this set-up phase. The managers teleconference weekly. The Operations Manager completes a report to the Director Care Homes and Rehab.

There are job descriptions for all management positions that include responsibilities and accountabilities.
Bupa provides a comprehensive orientation and training/support programme for their manager's and clinical managers and regular forums for both occur across the year. There is also a Bupa dementia care advisor that is available for support and training.

ARC,D17.3di (rest home), D17.4b (hospital), The manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

##### **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:**

The clinical manager registered nurse (RN) fulfils the manager role during a temporary absence with support from the Bupa operations manager or relief manager's. She has many years nursing experience and management experience in aged care.
The organisation has well developed policies and procedures that are structured to provide appropriate care for residents that require hospital (medical), rest home, and dementia level care. The manager consults with the Bupa dementia leadership group, gerontology nurse specialists, physiotherapist, dietitian, and mental health for older people.

Allied health staff are available by referral. The service has negotiated contracts for podiatrist, dietitian and General Practitioner (GP) services. Physiotherapy services are provided by the Bupa Care Services Physiotherapist.
The newly built rest home wing has been designed with input from evidence based practice models, resident and staff consultation, experiential evidence from the global Bupa Care Homes team, and from evaluation and identified improvements from previous Bupa NZ developments.

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:**

Register of Registered Nurse (RN) and Enrolled Nurse (EN) practising certificates are maintained, both at facility level and access via the Nursing Council of NZ website via the Bupa Intranet. 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. Five staff files sampled including the rest home unit manager (RN), a rest home enrolled nurse and three rest home caregivers provide evidence that appropriate human resource processes have been followed. All have a current performance appraisal.

The organisation 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. All staff working in the new wing currently work in the existing Ashgrove House (rest home facility) which will close the day the new wing is commissioned. All have completed a role specific orientation as sighted in the five staff files sampled.

There is an annual education schedule that is implemented at Cashmere View and covers all required training. In addition opportunistic education is to be provided by way of tool box talks. There is an RN training day provided through Bupa that covers clinical aspects of care - e.g. Dementia, Delirium. External education is available via the DHB.

A competency programme is to be implemented for all staff with different requirements according to work type (e.g. support work, registered nurse, cleaner). Core competencies are required to be completed annually and a record of completion is to be maintained as per Bupa processes. This has been completed for the five staff files sampled.

Bupa is the first aged care provider to have a council approved PDRP. The Nursing Council of NZ has recently 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.

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.

##### **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.

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

The appointment of appropriate service providers to safely 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.)*

##### **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 wage analysis schedule is based on the safe indicators for aged care and the roster is determined using this as a guide. There is a draft roster that provides sufficient and appropriate coverage for the effective delivery of care and support. A report is provided fortnightly from head office that includes hours and whether there are over and above hours.
The roster for the new wing has the unit coordinator working Monday to Friday, an EN or RN seven days a week on morning shift, a caregiver fromn6.45 to 3.15 and another from 7.30 to 12.30, an EN or senior caregiver from 1445 to 2315 and a caregiver from 1400 to 2100 and a caregiver from 2300 to 0700. The new wing has a link passage to the hospital so hospital staff are available to help if necessary in an emergency. Additionally there are activities five days per week and a physiotherapist for 3.6 hours five days per week.

##### **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 1.3.6: 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

**Attainment and Risk:** PA Moderate

**Evidence:**

The previous audit identified shortfalls around short term and long term care planning. A review of eight files for this audit (two rest home, two psychogeriatric and four hospital) identify that short term care plans are in use and appropriately documented for short term issues including wounds, weight loss, infections and oedema. This issue has now been addressed. Long term care plans are comprehensively addressed in two of the eight files sampled (one psychogeriatric and one rest home). Issues in other files include; 1) a rest home resident who does not have COPD or the use of w walking frame in the care plan and for who the evaluation includes the use of continence products but this has not been transferred to the care plan, 2) a psychogeriatric resident receiving thickened fluids and a mouli diet but the care plans states normal diet, 3) a hospital resident with epilepsy. A sensor mat and pain that are not addressed in the care plan and 4) a hospital resident where XXXXXXXX are documented in the care plan but there are no corresponding interventions (the plan has not been completed) and with XXXXXXXXX that are not included in the care plan. Improvement continues to be required around care plan interventions.

##### **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.

**Attainment and Risk:** PA Moderate

**Evidence:**

The previous audit identified shortfalls around short term and long term care planning. A review of eight files for this audit (two rest home, two psychogeriatric and four hospital) identify that short term care plans are in use and appropriately documented for short term issues including wounds, weight loss, infections and oedema. This issue has now been addressed. Long term care plans are comprehensively addressed in two of the six files sampled (one psychogeriatric and one rest home).

**Finding:**

1) a rest home resident who does not have COPD or the use of walking frame in the care plan and for who the evaluation includes the use of continence products but this has not been transferred to the care plan, 2) a psychogeriatric resident receiving thickened fluids and a mouli diet but the care plans states normal diet, 3) a hospital resident with epilepsy. A sensor mat and pain that are not addressed in the care plan, and 4) a hospital resident where a XXXXXXXX are documented in the care plan but there are no corresponding interventions (the plan has not been completed) and XXXXXXXX that are not included in the care plan.

**Corrective Action:**

Ensure care plans include interventions for all identified areas of need.

**Timeframe (days):** 60 *(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:**

The new wing has a treatment room that contains locked cupboards. The medications are stored in locked trolleys for each of the units. One of the trolley’s currently being used in Ashgrove House will be moved to the new wing when the new wing opens. 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 RN) must sign controlled drugs out. Regular weekly controlled drug checks are completed. A review of the drug trolleys in all units showed all eye drops dated and no unlabelled medications. This is an improvement since the previous audit.
The service uses four weekly robotic packs. Medication charts have photo ID’s. This is an improvement since the previous audit. 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.
There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medication charts. The medication folders include a list of specimen signatures and competencies. Four of 14 medication charts sampled identify the non-packaged regular medications are not always signed as administered. PRN administration records show the date and time for all medication files sampled. A review of three residents with blood glucose monitoring show this is occurring regularly. These are improvement since the previous audit.
Registered nurses, enrolled nurses or senior caregivers administer medications who have passed their competency administer medications. All 'medication competent' staff are responsible for medication administration in all areas. 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
Medication management was held in August 2013 with 13 staff attending.
There are currently six residents self-administering in the rest home. All have locked drawers and medication is stored in these. All new bedside cabinets in the new wing have lockable bedside drawers. The previous shortfall has been addressed.
The medication charts reviewed included alert stickers for; a) controlled drugs, b) crushed, d) allergies, and e) duplicate name. One resident in the psychogeriatric unit has polytears prescribed and being administers but the prescription does not document how many drops are to be administered or how often. This is an area requiring improvement. Four of fourteen charts sampled (three in Pioneer and one in the psychogeriatric unit) have XXXXXX medications charted PRN with no indication for use. This previously identified shortfall continues to require improvement. Of the 14 charts sampled there were no photocopies. This is an improvement since the previous audit.

D16.5.e.i.2; Four of four rest home, four of four psychogeriatric unit and six of six hospital medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.

##### **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 new wing has a treatment room that contains locked cupboards. The medications are stored in locked trolleys for each of the units. One of the trolley’s currently being used in Ashgrove House will be moved to the new wing when the new wing opens. 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 RN) must sign controlled drugs out. Regular weekly controlled drug checks are completed. A review of the drug trolleys in all units showed all eye drops dated and no unlabelled medications. This is an improvement since the previous audit.
The service uses four weekly robotic packs. Medication charts have photo ID’s. This is an improvement since the previous audit. 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.
There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medication charts. The medication folders include a list of specimen signatures and competencies. Four of 14 medication charts sampled identify the non-packaged regular medications are not always signed as administered. PRN administration records show the date and time for all medication files sampled. A review of three residents with blood glucose monitoring show this is occurring regularly. These are improvement since the previous audit.
Registered nurses, enrolled nurses or senior caregivers administer medications who have passed their competency administer medications. All 'medication competent' staff are responsible for medication administration in all areas. 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, subcutaneous fluids, blood sugars and oxygen/nebulisers
Medication management was held in August 2013 with 13 staff attending.
There are currently six residents self-administering in the rest home. All have locked drawers and medication is stored in these. All new bedside cabinets in the new wing have lockable bedside drawers. The previous shortfall has been addressed.
The medication charts reviewed included alert stickers for; a) controlled drugs, b) crushed, d) allergies, and e) duplicate name. One resident in the psychogeriatric unit has polytears prescribed and being administers but the prescription does not document how many drops are to be administered or how often. This is an area requiring improvement. Four of fourteen charts sampled (three in Pioneer and one in the psychogeriatric unit) have XXXXX medications charted PRN with no indication for use. This previously identified shortfall continues to require improvement. Of the 14 charts sampled there were no photocopies. This is an improvement since the previous audit.

**Finding:**

(i) Four of 14 medication charts sampled identify the non-packaged regular medications are not always signed as administered. (ii) One resident in the psychogeriatric unit has polytears prescribed and being administers but the prescription does not document how many drops are to be administered or how often. (iii) Four of fourteen charts sampled (three in Pioneer and one in the psychogeriatric unit) have XXXXX medications charted PRN with no indication for use. (iv) The treatment room in the new wing is not yet secure.

**Corrective Action:**

(i) Ensure medications are administered as prescribed. (ii) Ensure all prescriptions document the dose and frequency. (iii) Ensure PRN medications document an indication for use. (iv) Secure the treatment room in the new wing prior to opening.

**Timeframe (days):** 60 *(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:**

The existing kitchen is catering for the 54 potentioal residents at Ashgrove House and will continue to cater for these residents when 29 shift to the new wing. The new wing has a kitchenette that includes facilities to plug in the bain marie, a hot water urn, a dishwasher and a microwave.

All residents admitted to the facility are assessed by a registered nurse as to their individual food likes and dislikes. They are also assessed as to their nutritional needs, weighed on admission and a modified nutritional assessment completed (MNA). When a resident is identified as needing specific dietary requirements this is documented on their initial care summary and in the resident progress notes. The kitchen is given copies of these assessments and consequent dietary needs on the day of admission. Colour coded white boards are evident in the kitchen to guide staff in the individual needs of the residents. There is evidence of special diets being provided in the facility such as vegetarian meals and modified diets for those residents at risk of food and fluid aspiration. The cook interviewed described how resident likes/dislikes and special diets were provided to the kitchen.

Inspection of the kitchen evidenced equipment manuals available for use, routine cleaning schedules in use and regular monitoring of temperatures for fridges and freezers. The temperature of heated food is also routinely checked and documented before being served. The pantry is well stocked and managed with all food on appropriate shelving. Residents and families are surveyed annually regarding the food and its delivery and this was last circulated in 2013. A corrective action plan was established around aspects of the food service following the survey and this was discussed with residents. Resident meetings also discuss the food service and the cook or a kitchen representative often attends to get useful feedback.

All residents are weighed on admission and a food diary is initiated at this time also. When a resident is assessed as needing further intervention a nutritional care plan is developed. There is evidence of a dietitian referral for a resident in the rest home. There is evidence of residents being weighed monthly and for those residents needing closer monitoring evidence of weekly weighs.
D19.2: All kitchen staff have current food safety certificates.

##### **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:**

Chemical/substance safety policy (048). 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.
Specific waste disposal – infectious, controlled, food, broken glass or crockery, tins, cartons, paper and plastics.
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 is a spill kit. 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 required to be reported on the accident report form which is in turn investigated by the manager and reported to the Bupa Health and Safety Coordinator.
Material safety data sheets are available in the laundry and the sluices in each wing. Each sluice has a sanitiser.
All chemicals are clearly labelled with manufacturers labels. Advised that a sharps container will be kept in the treatment room in the new wings.
Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols.
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.

**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 Low

**Evidence:**

The facility is purpose built and is spacious. All building and plant have been built to comply with legislation. The organisation has purchased all new equipment. There is a current building warrant of fitness. A code of compliance has not yet been obtained for the new wing and this requires addressing prior to occupancy.
There are centrally located nurse station in the new wing with windows/doors opening out into the lounge area. This 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. The maintenance schedule includes checking of equipment and checks have been completed. All electrical equipment and other machinery has been checked as part of the annual maintenance and verification checks. All existing equipment at Ashgrove House will be transferred to the new wing on the day Ashgrove House closes and the residents are transferred to the new wing. Additional 15 hi-lo/electric beds have been purchased. There is a specific point for sensor mats so that they are not shared with the call bell system.

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 in the new wing for storage of mobility equipment.
All rooms and communal areas allow for safe use of mobility equipment.

There is a courtyard outside the new wing with paths for walking that have been landscaped.

There are environmental audits and building compliance audits which are completed as part of the internal audit programme.
There is a planned maintenance programme to ensure all buildings, plant and equipment are maintained. There is a full time maintenance/grounds person employed.

##### **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 Low

**Evidence:**

The facility is purpose built and is spacious. All building and plant have been built to comply with legislation. The organisation has purchased all new equipment. There is a current building warrant of fitness. The maintenance schedule includes checking of equipment and checks have been completed. All electrical equipment and other machinery has been checked as part of the annual maintenance and verification checks.

**Finding:**

A code of compliance has not yet been obtained for the new wing.

**Corrective Action:**

Ensure a code of compliance is obtained and provided to the DHB.

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

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

**Attainment and Risk:** 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 1.4.3: 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 is a mobility toilet near the lounge. Each resident room has either a shared ensuite (14 rooms) or single ensuite (15 rooms). All ensuites throughout the new wing allow for the use of mobility equipment. Shared ensuites have a locking system whereby when one door is locked or unlocked the other door to the ensuite automatically locks/unlocks. These can be opened if necessary by staff in an emergency.

##### **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:**

The 29 single esidents rooms in the new wing are large and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in en-suites and communal toilets/bathrooms in all areas. The open plan lounge area is spacious. Residents requiring transportation between rooms or services are able to be moved from their room either by trolley, bed, lazyboy or wheelchair.

##### **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 in the new rest home wing. The facility has a whanau room and a room that could be used for relative/resident dining.

##### **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:** FA

**Evidence:**

The existing laundry is catering for the 54 potentioal residents at Ashgrove House and will continue to cater for these residents when 29 shift to the new wing Cleaning department - use of equipment policy (051), cleaning schedule – nursing staff (057).
Cleaning schedule/methods – cleaners (053)
There is a laundry manual that contains (but is not limited to): safety, standard infection control practises, procedures for the laundry of linen, infected linen, a laundry flow chart, sluicing soiled laundry, washing, drying, the cleaning of the laundry and chemical safety and storage.

The laundry is large and located in the service area. The laundry is divided into a “dirty” and “clean” area (two doors for entrance and exit). Laundry staff are employed. There is a secure sluice room in the new unit with a sanitiser. Chemicals and the cleaning trolley will be kept in the secure sluice room. There are Multi Safety Data Sheets (MSDS) folders available in the laundry.

Audit laundry services and environmental hygiene - cleaning is completed twice each year as per internal audit schedule.
The laundry and cleaning room is a designated area and clearly labelled. Chemicals are stored securely. All chemicals are labelled with manufacturer’s labels. MSDS are available in folders in the laundry. Personal protective equipment (PPE) is available.

##### **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:** 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 1.4.7: 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:**

Appropriate training, information, and equipment for responding to emergencies is provided at induction and as part of the annual training programme. Staff training in fire safety and fire drill has been completed with the last fire drill in July 2014. The keypadded doors are connected to the fire alarm.
There is a comprehensive civil defence manual and emergency procedures manual in place. Civil defence kit is readily accessible in a storage cupboard.

Key staff are hold first aid certificate and a review of the roster indicates there is someone in the facility with a first aid certificate at all times.
Smoke alarms, sprinkler system and exit signs in place in the building. The fire evacuation plan is approved for the existing building but has yet to be signed off as approved by the fire service.
The facility has emergency lighting and torches. There are large water tanks available in the ceiling space. Gas BBQ and additional cylinders are available for alternative cooking. Emergency food supplies sufficient for three days are kept in the kitchen. Extra blankets are also available. The facility has civil defence kits.
The call bell system is available in all areas with visual display panels. Call bells are available in all resident areas, that is, bedrooms, en-suite toilet/showers, communal toilets, dining/rooms. The call bell system will also be connected to staff pages. The call bell system is yet to be connected. This will require addressing prior to occupancy.

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

Where required by legislation there is an approved evacuation plan.

**Attainment and Risk:** PA Low

**Evidence:**

The fire evacuation plan is approved for the existing building.

**Finding:**

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

**Corrective Action:**

Ensure the updated evacuation scheme is signed off by the Fire service.

**Timeframe (days):** 30 *(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:** PA Low

**Evidence:**

The call bell system is available in all areas with visual display panels. Call bells are available in all resident areas, that is, bedrooms, en-suite toilet/showers, communal toilets, dining/rooms. The call bell system will also be connected to staff pages.

**Finding:**

The call bell system is yet to be connected.

**Corrective Action:**

Ensure the call bell system is operational.

**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.

**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 1.4.8: 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. There is heat control panels in individual rooms. There is plenty of natural light in the new rooms and all have windows. There are skylights in the hallways.

##### **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 (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the IC programme policy and IC programme description is available. There is a job description for the IC coordinator and clearly defined guidelines. The infection control programme links to the quality and risk management system. The programme is reviewed annually at organisational level.
The service has monthly quality/ IC meetings. Towards the end of 2008, Bupa introduced a regional infection control group (RIC) for the three regions in NZ. The meetings are held six monthly and terms of reference are clearly documented. The IC coordinator attends the southern meeting.

##### **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:**

**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.)*