

# Bupa Care Services NZ Limited - Hugh Green Care Home

---

## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Bupa Care Services NZ Limited
<b>Premises audited:</b>	Hugh Green Care Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 27 March 2019 End date: 28 March 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	97

# Executive summary of the audit

---

## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Bupa Hugh Green Care Home provides rest home, hospital and dementia levels of care for up to 100 residents. There were 97 residents during the audit.

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

The care home manager is appropriately qualified and experienced. Feedback from residents and families was very positive about the care and the services provided.

An improvement continues to be required in relation to the previous shortfall around care interventions.

This surveillance audit identified a further improvement required around monitoring refrigerator temperatures.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

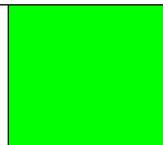


Standards applicable to this service fully attained.

Families and residents are kept informed. Complaints and concerns are being managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

The care home manager is supported by administrative staff, an acting clinical manager, registered nurses, caregivers and support staff.

Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family satisfaction is monitored via annual satisfaction surveys and regular meetings. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

Appropriate employment processes are adhered to. All staff undergo an orientation that is specific to their job description. A comprehensive education and training programme is implemented with a current plan in place. There is a roster that provides sufficient and appropriate staff cover for the effective delivery of care and support.

## Continuum of service delivery

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

The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. InterRAI assessment timeframes have been met. Care plans viewed in resident records demonstrated service integration. Care plans are evaluated at least six-monthly. Resident files include medical notes by the general practitioner and visiting allied health professionals.

Registered nurses and senior caregivers responsible for administration of medicines complete education and medication competencies. The medicine charts reviewed comply with prescribing requirements.

The diversional therapists and activity assistant implement an activities programme to meet residents' needs, preferences and abilities. The programme involves community visitors, outings, entertainment and activities.

All meals and baking are done on-site. Residents' food preferences and dietary requirements are identified at admission and accommodated. There is a four-week rotational menu that is reviewed by the dietitian. There are nutritious snacks available 24 hours a day.

## Safe and appropriate environment

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

The building holds a certificate for public use that is valid until 22 May 2019.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The service remains restraint-free and there were no residents using either restraints or enablers. Restraint management processes are available if restraint is required.

## Infection prevention and control

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

The infection control surveillance programme and its content are appropriate for the size, complexity and degree of risk associated with the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. The service engages in benchmarking with other Bupa facilities.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	1	0	0
Criteria	0	41	0	1	1	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint's register. Five complaints were lodged in 2018. Three were selected for review and indicated that timeframes met requirements set forth by the Health and Disability Commissioner. All complaints reviewed had a noted investigation, timelines determined by HDC were met, and corrective actions (where indicated) were actioned. All five complaints were documented as resolved. The final letter that is sent to the complainant includes contact details for HDC and HDC Advocacy Services. One complaint has been received in 2019 (year to date). An investigation is currently underway. Complainants are kept informed if the investigation exceeds 20 working days.</p> <p>Complaints are linked to the quality and risk management system. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. A record of family communication is held in the front of each resident's file.</p> <p>Ten incidents/accidents forms selected for review indicated that family were informed. Families interviewed confirmed they are notified of any changes in their family member's health status.</p> <p>Interpreter services are available if needed. Staff and family are utilised in the first instance.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Hugh Green Care Home is part of the Bupa group of aged care facilities. The service is certified to provide rest home and hospital (medical and geriatric) levels of care for up to 100 residents. On the day of the audit there were 97 residents (27 rest home level including one respite resident, 47 hospital level including one respite resident and 23 dementia level). All rest home and hospital beds are certified for dual purpose. At the time of the audit, all residents were on the aged residential care contract (ARCC).</p> <p>Bupa's overall vision and values are displayed in a visible location. All staff are made aware of the vision and values during their induction to the service. There is an overall Bupa business plan and risk management plan. There are documented quality/health and safety goals that are reviewed three-monthly and signed off when achieved. New goals are set every year in February.</p> <p>The care home manager has 30 years of experience in aged care. He has been employed by Bupa as a care home manager for Hugh Green since it opened in November 2016. His background in health care includes work as a physiotherapist in the UK. He is supported by an administrator, an acting clinical manager/RN and a unit coordinator/RN. In addition, a clinical advisor/RN and roving clinical manager/RN have been providing additional input and cover during the absence of a clinical manager and while he was (previously) on extended leave. The acting clinical manager has been in his role since November 2018. He previously was the unit coordinator for one level of the aged care facility (rest home and hospital level residents) and will return to this position following the appointment of a clinical manager. He has worked in aged care for four years.</p> <p>The care home manager and acting clinical manager have maintained over eight hours annually of professional development activities relating to their respective roles.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with two managers (care home manager, acting clinical manager) and fourteen staff (six caregivers across the am and pm shifts who work in the dementia (special care) unit (two), and with the rest home and hospital level residents (four), one clinical advisor, one unit coordinator/registered nurse (RN), one staff RN, one maintenance, two diversional therapists, one hospitality manager and one chef) confirmed their understanding of the implemented quality and risk management systems.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.</p> <p>Data collected (eg, falls, medication errors, wounds, skin tears, pressure injuries, complaints, challenging behaviours) are collated and analysed with results communicated to staff. Corrective actions are implemented where benchmarked data exceeds targets.</p> <p>An internal audit programme is in place. In addition to scheduled monthly internal audits, an annual facility health check is conducted by an external Bupa representative. Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented. Quality and risk data is shared with staff via meetings and posting results in the staff room.</p> <p>The last resident satisfaction survey was completed in August 2018. 81% of respondents would recommend the facility. The outcome of the satisfaction survey was 11% higher than the previous year.</p> <p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. The health and safety team meet once a month. Staff undergo annual health and safety training, which begins during their orientation. All staff are provided with information about their responsibility under the Health Safety at Work Act 2015. Hazard registers are maintained on each floor of the facility. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed.</p> <p>A facility goal remains around reducing the number of resident falls by 20%. A falls focus group has been implemented. Strategies implemented to reduce the number of falls include (but are not limited to) ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding. All residents have a falls risk assessment completed by a physiotherapist as part of their admission process. Interviews with caregivers confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers</p>	<p>FA</p>	<p>There is an accident and incident reporting policy. Adverse events are investigated by the acting clinical manager and/or RN staff, evidenced in all ten accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by an RN. Unwitnessed falls include neurological observations.</p> <p>Discussion with the care home manager confirmed his awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided (pressure injuries, a resident who absconded and one infectious (scabies) outbreak that included reporting to the public health authorities.</p>

and where appropriate their family/whānau of choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place, which include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. A register of current practising certificates for all health professionals (internal and external) who provide services is maintained. Six staff files reviewed (three caregivers, one staff RN, one acting clinical manager, one activities assistant) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements and job descriptions.</p> <p>The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. The education programme being implemented is extensive and includes in-service training, competency assessments, and impromptu (tool box) talks. Caregivers are expected to complete an aged care education programme that meets the New Zealand Quality Authority (NZQSA) requirements. Thirteen caregivers regularly work in the secure dementia unit. Twelve have completed the required dementia standards and the remaining one staff is enrolled and is scheduled to complete their qualification within 18 months of employment.</p> <p>The chef has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on-site. Chemical safety training is included in staff orientation and as a regular in-service topic.</p> <p>Five of eleven RNs have completed their interRAI training. The care home manager, acting clinical manager and staff are encouraged to attend external training courses.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A staff rationale and skill mix policy is in place. The care home manager has been on extended leave and has been supported by a relief care home manager/clinical manager and acting unit coordinator in his absence. He has recently returned to work and is employed full time. The acting clinical manager is an RN who is employed full-time (Monday – Friday). He is supported by a part-time unit coordinator/RN who has recently returned from extended leave. During RN shortages a clinical advisor/RN has been working at the facility two-three times a week.</p> <p>The care facility covers three floors with an elevator placed in an accessible location. The secure dementia unit (with 23 residents) is on the ground floor (level one) and the dual-purpose (rest home/hospital) beds are located on the second level (occupancy 44) and third level (occupancy 30).</p> <p>For the dementia unit, a unit coordinator/RN has recently been employed and soon begins part-time employment (three days a week). Until this time, staffing has included two long and two short shift caregivers on the AM shift, two long and one short shift staff on the PM shift and one caregiver on the night shift. The RN on level three has</p>

		<p>been providing oversight.</p> <p>Level two (twenty-seven hospital level residents and seventeen rest home level residents) is staffed with one RN on each shift. Two long and four short shift caregivers cover the AM shift, two long and three short shift caregivers cover the PM shift and two caregivers cover the night shift.</p> <p>Level three (ten rest home level residents and twenty hospital level residents) is staffed with one RN on each shift. Two long and two short shift caregivers staff the AM shift and PM shift. One caregiver covers the night shift.</p> <p>Additional caregiver support is available when needed. Extra staff can be called on for increased resident requirements.</p> <p>Activities staff are rostered seven days a week, with designated activities staff placed on each of the three floors. Separate cleaning and laundry staff are rostered.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>Comprehensive medication management policies and procedures are in place. Staff who administer medications (RNs and caregivers) have been assessed for competency on an annual basis. Registered nurses have completed syringe driver training. Education around safe medication administration has been provided annually. There is evidence of medication reconciliation on delivery of robotic roll medications against the medication chart on the electronic medication system. Prescribed medication is signed as administered electronically. All eye drops were dated on opening. The three fridges storing medication in the treatment rooms did not have daily temperature checks documented.</p> <p>Twelve medication charts reviewed (three rest home, five hospital and four dementia care) had photo identification and allergy status documented on their chart. The administration sheets corresponded with the medication charts. All medication charts evidenced three-monthly GP review.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this</p>	FA	<p>The food service is managed by the hospitality manager, who is supported by qualified chefs and kitchen assistants. Food services staff have attended food safety training. There are food service manuals in place to guide staff. All meals and baking are prepared and cooked on site in a well-equipped kitchen located within the service area of the facility. The food service manages the on-site café for resident and visitor use.</p> <p>The four-weekly seasonal menu has been reviewed by the dietitian. Menu boards in the dining rooms are updated daily by kitchen staff. Breakfasts are prepared in the unit kitchenettes. Meals are delivered in bain maries to the unit kitchenettes and served by staff. The cooks receive a resident nutritional requirement's form for new residents and are notified of any dietary changes. The menu provides a vegetarian option. Likes and dislikes are known.</p>

<p>service is a component of service delivery.</p>		<p>Special diets are accommodated, including diabetic desserts and high energy/protein diets. There were nutritious snacks available 24-hours in the dementia unit.</p> <p>Fridge, freezer end-cooked and serving temperatures are taken and recorded daily. Perishable foods sighted in the kitchen and facility kitchenette fridges were dated. The dishwasher is checked regularly by the chemical supplier. Chemicals are stored safely. A cleaning schedule is maintained.</p> <p>Resident meetings and surveys, along with direct input from residents, provide evidence of positive resident feedback on the meals and food services. Survey results with quality initiatives were sighted on the noticeboards in public areas. Residents and family members interviewed spoke positively about the food service and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The resident care plans in all files reviewed were individualised. All identified support needs as assessed were included in the care plans for two of six resident files reviewed. Short-term care plans were in use for changes to health status and have been resolved or if ongoing, transferred to the long-term care plan. The care plan for two dementia care residents did not include the management of weight loss and behaviours, triggers, and de-escalation techniques. This previous shortfall remains an area for improvement.</p> <p>Residents and their whānau/family interviewed confirmed they were involved in the care planning process.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including GP, podiatrist, dietitian, physiotherapist and mental health services. Staff interviewed stated they found the care plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP, nurse specialist consultation. On the day of audit, the nurse specialist was on site reviewing a resident for increased level of care. There was documented evidence on the family/whānau record page that family members were notified of any changes to their relative's health status.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation forms and evaluation notes were in place for the files reviewed. All wounds were reviewed in appropriate timeframes. There was one facility acquired pressure injury on the day of audit which evidenced input from the dietitian and wound care specialist.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Short-term care plans document appropriate interventions to manage short-term changes in health.</p>

		<p>The service has commenced the HEHP plan around weight management for residents with weight loss.</p> <p>Monitoring occurs for weight, vital signs, blood sugar levels, pain, challenging behaviour, repositioning charts, food and fluid, restraint and visual checks.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs two qualified diversional therapists (DTs) and an activity assistant to coordinate and implement the programme for each unit.</p> <p>The integrated activity programme covers seven days a week. The activity team provides individual and group activities for residents that meet their cognitive, physical and intellectual abilities. Activities include (but are not limited to) arts and crafts, music, exercises including Tai Chi, reminiscing, board games, card groups, poetry, movies and entertainment. Festive occasions and events are celebrated. Seating is arranged in all units to allow several small group activities happening at one time. Community links are maintained with visiting church groups, primary school children, volunteers with pets. Volunteers and students are involved in the activity programme. A group of volunteers are currently painting sensory and tactile murals in the dementia care unit. Residents in all units enjoy outings to places of interest, picnics and attending community concerts and community events such as art exhibitions. The residents were observed engaging with the pet therapy dog on the day of the audit.</p> <p>A diversional therapist implements the activities programme in the dementia unit. One-on-one activities occur such as individual walks, reading, chats and hand pampering for residents who are unable or choose not to be involved in group activities. As observed on the day of the audit there was active involvement in the group activity. A sensory room, office and nursery space forms part of the setup in the Shannon Unit.</p> <p>A resident activity assessment and Map of Life is completed on admission by the DT. Socialising and activities is included in the 'My Day, My Way' section of the care plan. The DT is involved in the six-monthly review. Copies of the activity programme were evident in residents' rooms visited. The service receives feedback and suggestions for the programme through surveys and resident meetings. Families are encouraged to be involved in the activity programme, outings and events.</p> <p>Residents and family interviewed spoke positively about the activities programme and team members.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	FA	<p>The resident files sampled demonstrated that all initial care plans reviewed were evaluated by the RN within three weeks of admission. The long-term care plans had been reviewed by the multidisciplinary team (MDT) at least six monthly or earlier for any health changes. Family are invited to attend the MDT review and are informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. The short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Nursing evaluations occur as indicated and are documented within the progress notes and are evident in changes</p>

timely manner.		made to care plans.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a code of compliance certificate posted in a visible location (expiry 22 May 2019). The building has three levels with lift and stair access.</p> <p>The service employs maintenance staff to ensure daily maintenance requests are addressed and a planned maintenance 52-week schedule is maintained. Essential contractors are available as needed 24/7. Equipment undergoes preventative maintenance checks (eg, hoists, wheelchairs). Medical equipment is calibrated annually (eg, scales). Each ensuite has a tempering valve that maintains water temperatures below 45 degrees Celsius. Water temperature checks are completed monthly as part of the 52-week planner.</p> <p>The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares.</p> <p>There are safe outdoor areas for residents including a secure garden area for the residents in the dementia unit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. Systems in place are appropriate to the size and complexity of the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections statistics are included for benchmarking. Corrective actions are established where trends are identified. There was a scabies outbreak in February 2019. Records reviewed reflected a comprehensive and effective approach from facility to the outbreak.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents using restraints or enablers.</p> <p>A registered nurse (supported by the acting clinical manager) is the restraint coordinator. She was unavailable for interview. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</p> <p>Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education including assessing staff competency on RMSP/enablers has been provided. Restraint is discussed as part of staff meetings and in separate restraint meetings.</p>

--	--	--

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Low	There are policies and procedures in place for safe medicine management. Medications are received from the pharmacy, reconciled and stored in the treatment rooms. Expired medications are returned to the pharmacy. The service uses an electronic medication system. The daily temperature check for the medication fridges in the three treatment rooms were not documented	The daily temperature check for the medication fridges in the three treatment rooms were not documented.	<p>Ensure documentation reflects medication fridges are monitored daily as per policy.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	Resident care plans identified the required needs and interventions to meet resident goals in four of six resident files reviewed. Short-term care plans had been completed for wounds, infections and short-term needs.	<p>i) The were no documented weight loss interventions for two dementia care residents.</p>	<p>i) Ensure care plans reflect the residents' assessed needs and supports.</p> <p>ii) Ensure there</p>

			ii) One dementia care resident did not have triggers, and de-escalation techniques documented to manage behaviours.	are triggers, and de-escalation techniques documented for residents with behaviours that challenge.  30 days
--	--	--	---	--

## Specific results for criterion where a continuous improvement has been recorded

---

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
--------------------

End of the report.