Bupa Care Services NZ Limited - David Lange 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:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	David Lange Care Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 14 October 2019 End date: 15 October 2019
Proposed changes to current services (if any):	

Total beds occupied across all premises included in the audit on the first day of the audit: 75

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

David Lange Care Home is part of the Bupa group of aged care facilities. The care facility has a total of 87 beds certified for rest home, hospital and residential disability (physical) levels of care. During the audit there were 75 residents at the facility.

This unannounced surveillance audit was conducted against a subset of the 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 and interviews with residents, family, management and staff.

The facility manager is a registered nurse with health management experience and works fulltime. She is supported by a clinical manager with experience in aged care.

There are well-developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who live in the service. Implementation is supported through the Bupa quality and risk management programme that is individualised to David Lange and has been embedded in practice. Quality initiatives are implemented which provide evidence of improved services for residents.

Six of six shortfalls identified at the previous audit have been rectified around orientation, training, integration of care documentation, care plan interventions, medication documentation and restraint monitoring

This audit identified that improvements are required by the service around timeliness of assessments and care plans and care monitoring.

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.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The care home manager is supported by a clinical manager; unit coordinators, registered nurses, caregivers and support staff.

The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored via annual satisfaction surveys.

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. An education and training programme is established. The roster provides sufficient and appropriate staff cover for the effective delivery of care and support.

Continuum of service delivery

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

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. Care plans reviewed in resident records were individualised and demonstrated service integration. Care plans are evaluated at least six monthly. InterRAI assessment timeframes had been met. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for administration of medicines complete education and medication competencies. The medicine charts reviewed met legislative prescribing requirements.

Activity assistants coordinate and implement the activity programmes for the residents. The programmes include community visitors, outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group including younger people.

All meals and baking are prepared on site. Residents' food preferences and dietary requirements are identified at admission and accommodated. The menus are reviewed annually by the BUPA dietitian. Residents commented positively on the meals provided.

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 current warrant of fitness (expires 18 April 2020). Communal areas within each area/community are easily accessed with appropriate seating and furniture to accommodate the needs of the residents. External areas are safe and well maintained. Fixtures fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Hot water temperatures are monitored.

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. There were no residents using restraints and five residents using enablers during the audit. A registered nurse is the designated restraint coordinator. Staff are offered training in restraint minimisation and challenging behaviour management, which begins during their orientation to the service.

Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

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	16	0	2	0	0	0
Criteria	0	44	0	2	0	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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. Clinical staff interviewed (five caregivers, four registered nurses, two-unit coordinators and three activity staff) were able to describe the process around reporting complaints. There is an electronic complaint register (Riskman) as well as paper-based copies of complaints in a file. Eleven complaints have been logged for 2019 year to date. Ten of the eleven complaints indicated in the complaints register that they were closed following an investigation. Timelines determined by HDC were met, and corrective actions (where indicated) were actioned. The complainant was kept informed throughout the complaints process. Three complaints reviewed in-depth documented an action plan and education for staff as needed through the toolbox talk process. Complaints are discussed in quality meetings. One complaint, around alleged lack of care is currently under investigation by the Bupa quality team. Discussions with five rest home and three hospital level residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns. A recent complaint had been received via the DHB around wound care. The service has implemented an in-depth action plan. Remedial actions included; wound care education for all registered nurses by the wound care specialist; all RNs have completed an on-line wound care course, and all RNs have completed the Bupa Wound

		competency. The two weekly clinical review meetings for RNs discuss wounds and wound care. The service has strengthened links with the virtual wound care resource and the process to access specialist dressings have been implemented.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. The care home manager and clinical manager confirmed family are kept informed. Relatives (two hospital and one rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents and each resident file included a family communication log. Relatives interviewed stated they are notified promptly of any changes to residents' health status. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	David Lange Care Home is part of the Bupa group of aged care facilities. The care facility has a total of 87 beds suitable for rest home, hospital and residential disability (physical) levels of care. Hospital level of care is certified for geriatric and medical. During the audit there were 75 residents at the facility (28 rest home and 47 hospital (including three younger person disabled). All rest home and hospital beds are certified for dual purpose. 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 monthly and signed off when achieved. The care home manager has been in the role for a year. She is a registered nurse with 21 years' experience in elderly care. She is supported by a clinical manager/RN and two-unit coordinators/RNs. The clinical manager has been in the role for six months having previously been a unit coordinator at David Lange. The GP praised the new management team and stated that improvements were ongoing since they commenced in the roles. The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.
Standard 1.2.3: Quality And Risk Management	FA	A quality and risk management programme is in place. Interviews with the care home manager, clinical manager, four RNs, two-unit coordinators, five caregivers, a cook, one maintenance staff, and three activity staff confirmed their understanding of the quality and risk management systems.

Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		Policies and procedures and associated implementation systems provide a good level of assurance that the facility 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. Policies and procedures include reference to interRAI for an aged care service and meet current health and safety legislative requirements. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, pressure injuries and wounds. Quality data is entered into the organisational Riskman data base where results are benchmarked against quality indicators. A corrective action plan is required for any results above the quality indicator and any adverse trends over three months. An annual internal audit schedule including environmental, support services and clinical audits was sighted for the service. The new manager reviewed all audits on her arrival to the service which noted a gap in the internal audit process, an action plan was commenced to bring audits up to date and follow up on action plans for audits completed prior to her arrival. Since this time all audits had been completed as per schedule and where the result was less than expected corrective action plans had been developed and re-audits completed. Quality and risk data, including trends and benchmarked results are discussed in monthly quality meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed. A range of meetings are also held including monthly RN meetings, as well as laundry, kitchen, caregivers and activities meetings. The clinical manager holds two weekly clinical review meetings. Clinical issues including (but not limited to); new residents, residents with weight loss/gain, falls, incidents, admissions to or from hospital and wounds are discussed. The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. 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. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. Strategies are implemented to reduce the number of falls. This includes (but is not limited to) ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, physiotherapy input and intentional rounding.
Standard 1.2.4: Adverse Event Reporting	FA	There is an accident and incident reporting policy. All adverse events/incident/accidents are entered on to the Riskman system. Adverse events are investigated by the registered nurse at the time of the event and by the clinical manager each month, evidenced in all ten accident/incident forms reviewed. Adverse events are linked to the quality and risk management programme. There is evidence to support actions are undertaken to minimise the

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations. Discussion with the care home manager and clinical manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. Examples have included one stage three pressure injury, one flu outbreak July 2019. There were two examples of serious event follow-up including the DHB complaints and an ongoing investigation by the Bupa quality team.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resource management policies in place which includes 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 is maintained. Six staff files reviewed (two caregivers, two RNs, one activities assistant and one kitchen assistant) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements and job descriptions. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Completed orientations were evidenced on all files. The new manager had reviewed all files and ensured that all staff have a completed orientation and scheduled performance appraisals. Each staff member had an up-to-date annual appraisal. Orientation and appraisals are an improvement from the previous audit. Education includes in-services, competency assessments and impromptu 'toolbox' talks. Education topics cover subjects relevant to young people with physical disabilities. The service has improved education since the previous audit with a wide range of education sessions. Education has been repeated to ensure that as many staff as possible can attend and this is improved attendance rates. 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. Four of thirteen RNs have completed their interRAI training. RNs have also completed first aid/CPR training and provide cover on-site 24/7. Activities staff who take residents on outings hold current first aid certificates; this is an improvement from the previous audit.
Standard 1.2.8: Service Provider Availability Consumers receive	FA	A staff rationale and skill mix policy is in place. Staffing on each wing is determined by resident acuity. The care home manager and the clinical manager are RNs who are employed on a full-time basis (Monday – Friday). They are supported by two-unit coordinators/RNs (Monday – Friday) Sufficient staff are rostered on to manage the care requirements of the residents. The facility covers three floors

timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		with an elevator placed in an accessible location. All beds are certified for dual-purpose. Residents are placed in the most appropriate room, which is based on bed availability, the resident's comorbidities (eg, high falls risk, disease complications), RN input required, and the resident's language spoken. The ground floor (Orion) is predominately rest home level residents (thirteen rest home and eight hospital). It is staffed with two caregivers on the AM and PM shifts (two long shifts) and one caregiver on the night shift. The staff RN and unit coordinator provides support shared with the top floor. The middle floor includes two wings and is predominately hospital level of care with 25 hospital and nine rest home. There is an RN on the AM shift plus a unit coordinator and two RNs for the PM shift. Four caregivers are rostered during the AM and PM shifts (four long). The top floor (Gemini wing) has 14 hospital and six rest home level residents. Two caregivers cover the AM and the PM shifts. Four activities staff are rostered five days a week, which also accounts for the day care programme that includes four residents per day. Separate cleaning and laundry staff are rostered. Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.
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.	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. Staff who administer medications (RNs, enrolled nurses and medication competent 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 medications (robotic rolls). The three medication fridges had temperatures monitored and recorded daily and these were maintained within the acceptable temperature range. All eye drops were dated on opening. Standing orders are not used by the service. There were four self-medicating residents on the day of audit. All four had updated medication competencies on file. Twelve medication charts on the electronic medication system were reviewed (including one resident receiving oxygen therapy). Medication folder of resident on oxygen therapy was audited and prescription was verified. Previous findings on medication management had been adequately addressed. All medication charts met prescribing legislative requirements for regular and 'as required' medications. All twelve medication charts had photo identification and allergy status documented on the chart.
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	All meals and baking are prepared and cooked on-site by a qualified head chef (Monday-Friday) who is supported by a weekend cook and four kitchenhands. The head chef also oversees the procurement of the food and management of the kitchen. All kitchen staff have completed food safety training. The organisational four-weekly

Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		seasonal menu has been reviewed by the company dietitian. The menu has a vegetarian option and diabetic desserts. Modified meals are also provided. An alternative menu, a daily Indian menu and a two-day a week Pacific Island menu is provided to residents that prefer other cultural choices. The chef receives a resident's nutritional requirement form on admission and is notified of any dietary changes. The daily menu is displayed in all the dining areas. Fridge, freezer and end cooked meat temperatures are taken and recorded daily. Perishable foods sighted in the fridges were date labelled. The dishwasher is checked regularly by the chemical supplier. Staff have received training in chemical safety. Chemicals are stored safely. A weekly and monthly cleaning schedule is maintained. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are conducted to monitor performance and quality interventions implemented to address shortfalls. The food control plan expires on 22 September 2020. Residents in the Orion wing are served their meals directly from the bain marie in the main kitchen. Meals are delivered to the kitchenettes in wings (Pegasus, Phoenix and Gemini) in bain maries and served by the care staff. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices and cultural meals were enjoyed.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The resident's files reviewed had detailed interventions in place relevant to their identified needs. An extended sampling of the resident on oxygen therapy reflected detailed interventions in the LTCP. The resident with a pressure injury had adequate interventions in place. Continence care plans for residents with incontinence was evidenced. This is an improvement on the previous audit.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	PA Low	When a resident's condition alters, the registered nurse initiates a review and if required, GP, nurse specialist consultation. There was documented evidence that family members were notified of any changes to their relative's health status. Changes to residents' health and required supports is updated on the care plans. Adequate dressing supplies were sighted in the treatment rooms. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for nine hospital residents with wounds (five chronic leg ulcers, two skin tears, one cyst and one excoriation wound). There was one hospital resident with a facility acquired deep tissue injury on the day of audit. All relevant wound care documentation was in place. Photographs demonstrated progress towards wound healing. The wound nurse

desired outcomes.		specialist is available as a virtual resource for advice on wound care management. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified. Monitoring charts were in place for weekly and monthly weights and vital signs, blood glucose, pain, turning charts and behaviour monitoring as required, however one hospital level resident with PEG tube did not have hourly PEG feed monitoring recorded and one rest home resident who had weight loss identified did not have daily food and fluid chart recordings completed. Two hospital level residents with enablers did not have regular monitoring updates documented in the progress notes.
Standard 1.3.7: Planned Activities 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.	FA	The service employs five activity assistants to provide an integrated rest home and hospital activities programme from Monday to Friday. The team is led by a qualified diversional therapist. The care staff oversee the programmes over the weekends. All five staff members have attended BUPA activity study days and have current first aid certificates. Two activity assistants are currently completing the diversional therapy course and the other two are on Careerforce level two. Each wing has its own activity programme and some activities are held facility wide. The activities programme includes bingo, bowls, pet therapy, board games, weekly movies and word games and a knitting club. There are regular musical entertainers and visitors to the facility including school choirs, school children and babies and visitors with their dogs. There are twice weekly (Mondays and Fridays) van outings to places of interest, shops and cafés, picnics, community functions and inter-home bowls competitions. The team of activity staff provide activities that meet the diverse cultural needs and requests of residents, including Samoan week, Diwali and Māori language week. Events such as birthdays, Easter, Mother's Day and ANZAC Day are celebrated. Residents are encouraged to maintain community links such as library visits, shopping outings into the community. Church services are held regularly. One-on-one activities occur such as individual walks, reading and chats and nail/hand care for residents who are unable or choose not to be involved in group activities. Individual activities are identified for residents under 65 years of age and residents are supported and encouraged to attend community activities of their choice. An activity assessment and Map of Life is completed for all residents on admission. Socialising and activities are included in the My Day, My Way care plan. The activity assistants are involved in the six-monthly MDT review. The service receives feedback and suggestions for the programme through surveys and resident meetings. Residents and family members interviewed stated the activity programme was varied and there were lots to choose from.
Standard 1.3.8: Evaluation Consumers' service	FA	The registered nurses evaluate all initial care plans within three weeks of admission (link 1.3.3.3). The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status (link 1.3.3.3). There is at least a one-three monthly review by the GP. All changes in health status are documented and followed up. Care

delivery plans are evaluated in a comprehensive and timely manner.		plan reviews are signed by an RN. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is posted in a visible location (expiry 18 April 2020). There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. There are safe outdoor areas for residents.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections are entered into the electronic data base for benchmarking. Corrective actions are established where trends are identified. There has been one confirmed flu outbreak in July 2019. HealthCERT and Public Health were notified with ongoing correspondence during the outbreak period. Case logs and outbreak documentation was sighted.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint is discussed as part of staff meetings and in separate restraint meetings. Documented systems are in place to ensure the use of restraint is actively minimised. There were no residents using restraints and five residents using enablers at the time of the audit. The clinical manager is the restraint coordinator, who understands strategies around restraint minimisation and assists with staff education around restraint minimisation. Staff interviews evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Education and competencies on restraint minimisation are scheduled annually. Two residents' files reviewed where an enabler was being used (bedrails) reflected an assessment and consent

		process had been completed with regular reviews. Residents using an enabler did not document any monitoring (link 1.3.6.1).
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all enabler documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing an enabler. An internal restraint audit, conducted annually, monitors staff compliance in following restraint procedures. There were no residents with restraint so monitoring of restraint was not able to be audited (link to 1.3.6.1 for enabler monitoring).

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)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Registered nurses (RNs) are responsible for the residents' assessments and the development of nursing care plans. The review of the residents' files reflected that not all documentation was completed within expected timeframes.	(i) Two hospital and two rest home residents did not have interRAI assessments and long-term care plans completed within 21 days of admission. (ii) Three hospital and two rest home residents did not have routine 6 monthly interRAI assessments and long-term care	(i) Ensure an interRAI assessment and long-term care plan is completed within 21 days of admission. (ii) Ensure routine 6 monthly interRAI assessments and long-term care plan evaluations are

			plans evaluations completed on time.	completed on all long-term residents. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Interviews with the unit coordinators and registered nurses demonstrated an understanding of the assessment, monitoring and management plans. Monitoring forms are used to monitor residents' health and well-being including blood pressure and pulse, weight, blood sugar levels, behaviour, food and fluid intake. Short-term care plans sighted on the day of audit included wounds, skin tears and identified weight loss. These had been reviewed regularly and signed off when resolved or transferred to the long-term care plan.	(i) One hospital level resident for daily PEG Feed monitoring did not have monitoring documentation completed. (ii) One rest home resident with identified weight loss did not have the daily food and fluid monitoring chart completed. (iii) Two hospital level residents with enablers did not have regular monitoring updates recorded in the progress notes.	(i) Ensure hourly monitoring of PEG feeds are completed and recorded. (ii) Ensure food and fluid chart monitoring is recorded as prescribed. (iii) Ensure residents with enablers have monitoring updates recorded in progress notes as per policy. 90 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, these 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.