

# Bupa Care Services NZ Limited - Rahiri Lifestyle Care & Village

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## Introduction

This report records the results of a Certification 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 BSI Group New Zealand Ltd, 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>	Rahiri Lifestyle Care and Village
<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: 20 April 2021    End date: 21 April 2021
<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>	49

# Executive summary of the audit

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## 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 Rahiri is certified to provide rest home, hospital and dementia level of care for up to 49 residents. At the time of the audit there were 49 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The care home manager has been in the role for nearly four years. She is supported by an experienced clinical manager who has been in the role for twelve months.

Residents and relatives interviewed spoke positively about the service.

There is a continuous improvement awarded around infection control.

## 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.

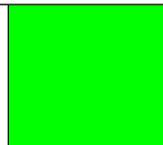


Standards applicable to this service fully attained.

Bupa Rahiri endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is inherent and celebrated. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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.

Services are planned, coordinated and are appropriate to the needs of the residents. A care home manager and clinical manager are responsible for day-to-day operations. Quality/health and safety goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan includes in-service education and competency assessments.

## 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.		Standards applicable to this service fully attained.
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There is an admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner and nurse practitioner as well as visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior medication competent caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the general practitioner or nurse practitioner.

The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals. Snacks are available at all times.

## 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.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are all single rooms with hand basins, eleven have ensuite and the rest share toilets and showers. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

## 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.
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There is a restraint policy in place that states the organisation's philosophy is restraint minimisation. The service continues to maintain a restraint free environment. There was one resident using an enabler during the audit.

## 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.
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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 is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is

used to determine infection control activities and education needs within the facility. There was one outbreak in 2019. This was well managed and appropriate authorities were notified.

## 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	1	92	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (three caregivers, three registered nurses (RN), one activities coordinator, the clinical manager and care home manager), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (two rest home including one young person with a disability (YPD), four hospital including one long-term chronic health care (LTS-CHC) and one respite and one dementia). Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. In the dementia unit the resident file sampled had an activated EPOA.</p>

give informed consent.		
Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information about the National Health and Disability Advocacy Service is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. They have also created ongoing relationships with community groups that visit Bupa Rahiri. Resident and relative meetings are held bi-monthly.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints received is maintained by the care home manager using a complaints' electronic register. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms and a suggestion box are placed at reception. Six complaints made in 2020 and one received in 2021 year to date were reviewed. All complaints reviewed had documented evidence of follow up, feedback to the complainant or outcome resolution.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The care home manager and clinical manager discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the resident/family meetings. Six residents (four rest home and two hospital) and five relatives (two hospital, one rest home and two dementia care) interviewed, reported that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit, there was one resident who identified as Māori living at the facility. One Māori resident interviewed confirmed that Māori cultural values and beliefs are being met. Māori consultation is available through the documented iwi links and Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. Caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. Care plans reviewed included the resident's spiritual and cultural needs.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is evident, promoting and encouraging good practice. The service receives support from the district health board, which includes nurse specialist visits. Physiotherapy services are available as requested. There is a regular in-service education and training programme for staff. The service has links with the local community and encourages residents to remain independent. Bupa has established benchmarking groups for rest home, hospital, dementia and psychogeriatric/mental health services. Bupa Rahiri is benchmarked against the rest home, hospital and dementia services data. If the results are above the benchmark, a corrective action plan is developed by the service. The service demonstrated a number of examples of good practice including not using any restraint.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms (electronic system) have a section to indicate if next of kin have been informed (or not) of an accident/incident. Eleven accident/incident forms reviewed identified that all families were kept informed (the twelfth was a staff incident). Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. An introduction to the dementia unit booklet provides information for family, friends and visitors to the facility. This booklet is included in the enquiry pack along with a resident's handbook providing practical information for residents and their families.</p>
<p>Standard 1.2.1: Governance</p>	<p>FA</p>	<p>Bupa Rahiri is certified to provide rest home, hospital (medical and geriatric) and dementia level of care for up to 49 residents. There are 26 dual-purpose beds (rest home and hospital). In addition, there are twelve hospital rooms, three rooms in the rest home which are smaller and are used for mobile rest home residents and an eight-</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>bed dementia unit. At the time of the audit there were a total of 49 residents (24 rest home residents including 1 younger person's disability [YPD] and 1 respite resident, 17 hospital residents [including 1 resident on respite with CMI funding and 1 resident on LTS-CHC funding] and 8 dementia level of care residents.</p> <p>Bupa's vision and key values are displayed on the wall. There is an overall Bupa business plan and risk management plan. Additionally, each Bupa facility develops an annual quality plan. Bupa Rahiri has set specific quality goals for 2020-2021 year. Progress with the quality assurance and risk management programme is monitored through the Bupa managers' meetings and various facility meetings. Monthly and annual reviews are completed for all areas of service. The organisation has a clinical governance group, which meets two-monthly. Bupa has robust quality and risk management systems implemented across its facilities with four benchmarking groups established for rest home, hospital, dementia and psychogeriatric/mental health services.</p> <p>The care home manager has been in the role for nearly four years. She is supported by a clinical manager who has been in the position for one year. Care home managers and clinical managers attend annual organisational forums and regional forums six-monthly. On first day of audit the People Partner for Bupa Central was visiting the site and the Operations Manager Bupa Central visits regularly and is readily available for support as needed.</p> <p>The care home manager has completed in excess of eight hours of professional development in the past twelve months.</p>
<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>During the temporary absence of the care home manager, the clinical manager or a Bupa relieving care home manager covers the care home manager's role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>FA</p>	<p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the Bupa support office via the electronic data system. Discussions with the managers and staff reflected staff involvement in quality and risk management processes.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>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.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents' falls, infection rates, complaints received, restraint use, pressure injuries, wounds and medication errors. Quality and risk data, including trends in data and benchmarked results are discussed in the quality and staff meetings. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Internal audits that were not fully compliant, had corrective actions initiated or completed. The resident satisfaction survey for 2020 resulted in 9.1 (out of 10) for overall satisfaction, up on the 2019 score which was 8.3 for resident overall satisfaction.</p> <p>Health and safety goals are established and regularly reviewed. Health and safety policies are implemented and monitored by the Health and Safety Committee. The health and safety officer (registered nurse) was interviewed about the health and safety programme. Risk management, hazard control and emergency policies and procedures are implemented. Hazard identification forms and a hazard register are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. All new staff and contractors undergo a health and safety orientation programme. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats and chair alarms.</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 and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual reports (electronic) are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Twelve accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Data collected on the electronic system is linked to the quality management system. Any incident rating higher than two out of five is escalated to support office. The care home manager and clinical manager are aware of their requirement to notify relevant authorities in relation to essential notifications with examples provided.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one clinical manager, one RN, two caregivers, one diversional therapist, one maintenance</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>person and one cook) included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. A register of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. A total of sixteen caregivers are employed to work in the dementia unit with fourteen staff on site with credits four dementia and five more are close to finishing.</p> <p>Registered nurses are supported to maintain their professional competency. Thirteen registered nurses (including the care home manager, the clinical manager and a casual RN) are employed. Eight have completed their interRAI training. There are a number of implemented competencies for registered nurses including (but not limited to) medication competencies and wound care.</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>	<p>FA</p>	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. Rosters implement the staffing rationale. There is a fulltime care home manager and clinical manager. The hospital area is staffed with at least one registered nurse on each shift and three carers on morning and afternoon and one on night. In the rest home area there are three carers on morning duty, two on afternoon and one on night (on some shifts a caregiver is replaced by a second RN). In the dementia unit there are two carers on morning and afternoon and one on night (on some morning and afternoon shifts a carer may be replaced by a RN). The interviews with residents and relatives confirmed staffing overall was satisfactory but there were times when staff appeared very busy. Caregivers advised that sufficient staff are rostered on for most shifts. All registered nurses and senior staff are trained in first aid. One RN has allocated time to spend with dementia residents and along with the clinical manager has a good understanding of the residents' needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being held securely in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care staff.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term and one respite admission agreements sighted were signed and dated.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Policy describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. Communication with family is made.</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>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were three residents self-administering on the day of audit. All policies and procedures had been adhered to. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and senior medication competent caregivers administer medications. All staff have up-to-date medication competencies and there has been medication education this year. The medication fridge and room temperature are checked daily. The room temperature has been slightly raised at times, but an action plan is in place and the facility are in the process of installing fans. To mitigate the risk, medications are moved to the other medication room when temperatures are higher. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on the electronic system. Fourteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP/NP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed.</p> <p>There were eight medication errors relating to administration in the period January 2020 to May 2020. A corrective action plan was formulated in May 2020. Toolbox talks (staff lead), and RN meetings were held more frequently. Senior caregiver meetings were established and these medication errors relating to administration were discussed.</p>

		<p>Reflective sessions were completed every time an error occurred. January 2020-April 2020: There were eight errors relating to administration; January 2021-April 2021 there were two errors relating to administration. The service identified there was a much-reduced error rate in 2021 versus the same period in 2020. The change to make less medication errors took time to fully embed but has been successful.</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 service is a component of service delivery.</p>	FA	<p>The service has a kitchen manager who works four days a week and a cook who covers the other days. There are also two relief cooks. There are two fulltime kitchenhands and three relief kitchenhands. All but two kitchen staff have food safety certificates and the other two are currently completing food safety. The kitchen manager oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen, and all meals are cooked on site. Meals are served in the dining rooms from a bain marie or hot box. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted in a folder. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals. Snacks are always available. The food control plan was verified on 21 September 2020.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents should this occur and communicates this to residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but were not limited to) nutrition, pain and continence.</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>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the hospice nurse, wound care nurse and mental health care team for older people. The care staff interviewed advised that the care plans were 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 changes the registered nurse initiates a GP/NP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed.</p> <p>Resident falls are reported on an electronic register and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family is notified.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are documented, and wound monitoring occurs as planned. There are currently nine wounds being treated One chronic wound has had input from the GP/NP and the wound care nurse specialist. There is currently one stage one pressure injury which has almost healed.</p> <p>Monitoring forms are in use as applicable such as weight, vital signs, wounds and behaviour.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as</p>	<p>FA</p>	<p>There is a diversional therapist (DT) who works 30 hours a week. On the days of audit rest home and hospital residents were observed going for a van outing, playing housie and listening to a volunteer playing the piano. In the dementia unit residents were singing along to songs from the world war two era.</p>

<p>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>		<p>There is a weekly programme in large print on noticeboards and residents have a copy in their rooms. The programme in the dementia unit can vary from the printed programme due to residents' mood and fatigue. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. There is a garden, sewing and knitting group. The knitting group sells their work from a stand in reception.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one on one visits to check if there is anything they need and to have a chat. There is an interdenominational church service every Sunday and the first Wednesday of the month. There are van outings every Thursday. They may go on picnics, shopping, men's club or cafés. There are entertainers visiting the facility every two months. Special events such as birthdays, Easter, Anzac Day, and Queens's birthday are recognised and celebrated.</p> <p>There is a hospital cat, the maintenance person brings his dog in daily and canine friends visit fortnightly. There is community input from volunteers and school groups. Two residents go to Elske on a Monday and Wednesday. Many residents like to take neighbourhood walks. The YPD resident is blind and prefers one on one visits.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan. Resident meetings are held two-monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Six care plans reviewed had been evaluated by the registered nurses six monthly or when changes to care occurs. A written evaluation is completed that describes progress to meeting goals. Where the evaluation reflects change in health status or usual activities this is updated in the care plan. The respite care plan was not due for review. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP/NP and resident/family if they wish to attend. There are three monthly reviews by the GP/NP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse and the hospice. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

<p>access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff.</p>
<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>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 20 January 2022. There is a maintenance person who works 30 hours a week. There is a contracted garden person. Electrical and plumbing contractors are available when required.</p> <p>There is a preventative and reactive maintenance schedule. Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The rest home and hospital are carpeted. The dementia unit is to be carpeted soon (on the refurbishing budget). Corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is a large enclosed outdoor area for the dementia unit. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>Staff interviewed stated they have adequate equipment to safely deliver care for rest home, hospital and dementia level of care residents.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	<p>FA</p>	<p>All rooms have hand basins. There are eleven rooms with ensuites and the rest share communal toilets and showers and there are sufficient numbers of these. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if required. There are signs on all shower/toilet doors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All rooms are single. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining</p>	<p>FA</p>	<p>In all units there are large and small communal areas. The larger areas are used for activities and the smaller areas are for residents to read, entertain visitors or just have quiet time. The dining areas are of an adequate size.</p>

needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All cleaning is done on site by four cleaners who also complete laundry duties. The laundry is divided into a “dirty” and “clean” area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored. There are three sluice rooms for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept closed when not in use. Cleaning trollies are locked away when not in use. Ironing is completed at night by caregivers.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>An approved fire evacuation plan is in place. There are emergency management plans to ensure health, civil defence and other emergencies are included. Fire evacuation practice documentation was sighted. The last planned fire evacuation drill occurred January 2021, however since then there has been one in March and April (triggered by insects in smoke detectors). A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and ongoing education for staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water and gas cooking. Short-term back up power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents’ room and lounge/dining room areas. Residents were observed to have their call bells where they could be easily accessed, or sensor mats were in use when required.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. Heating is a mixture of electrical and gas. Staff and residents interviewed stated that both are effective. There are two outdoor areas where residents smoke. All other areas are smoke free. Smoking cessation programmes are offered.</p>

temperature.		
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>Due to the Covid-19 pandemic it was evident that infection control practices needed to be more effective. In consultation with the integration and planning lead at MidCentral DHB they (Bupa Rahiri) identified that whilst they believed their staff were competent at putting on and taking off personal protective equipment (PPE) they did not have any records of how and when this was completed.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator has completed online DHB and Bupa infection control education. This is updated annually. During Covid-19 there has been regular information from Bupa support office.</p> <p>The facility has access to an infection control nurse specialist through the DHB, public health, GP/NP, local laboratory and expertise from within the Bupa company.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are</p>	FA	<p>There are comprehensive infection control policies that are current and reflect standards, legislation and good practice. These policies are developed by support office and are reviewed annually. There is resource information and plans around Covid-19 from support office and from the facility.</p>

<p>readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training is provided at orientation and as part of the annual training schedule. All staff complete hand hygiene audits. In-services have been provided around PPE and outbreak management and there has been particular emphasis on this since Covid-19. Any new communication regarding Covid-19 is relayed to staff in meetings, on noticeboards and at handovers.</p> <p>Resident education occurs as part of providing daily cares.</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>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is sent to support office and discussed with the care home manager and at quality and staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility. Benchmarking against other Bupa facilities occurs. There was a Norovirus outbreak in 2019. This was reported to the appropriate authorities. The outbreak was well managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirmed their understanding of restraints and enablers. Bupa Rahiri is a restraint free home and has been for over two years. At the time of the audit, the service had one resident using an enabler (bedsides at night). Consent documentation was in place and potential risks recorded in the care plan. The resident was monitored four-hourly, and this was noted in the progress notes.</p>

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## Specific results for criterion where corrective actions are required

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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.

No data to display
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## 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 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	CI	Due to the Covid-19 pandemic it was evident that infection control practices needed to be more effective. In consultation with the integration and planning lead at MidCentral DHB they (Bupa Rahiri) identified that whilst they believed their staff were competent at putting on and taking off personal protective equipment (PPE) they did not have any records of how and when this was completed.	They utilised a CMDHB PPE donning and doffing video and played this to staff. They further decided that a checklist to assess staff against would be particularly useful. The IC coordinator developed a checklist for donning and doffing procedure, adapted from the above video, as this met the current evidence base. The checklist was assessed by the Bupa national infection control lead and it was decided that Bupa would roll out the checklist across the country. This supported Bupa’s ongoing commitment to ensuring Bupa staff had the most up-to-date knowledge and skill. As PPE resources were scarce at the time the facility decided that a ‘talk me through’ the application process at morning huddles would be the best use of resources whilst assessing competence. As well as adopting this checklist for all new staff and annually for existing staff, not only at this facility but across Bupa, it has reduced their infection rates in residents without known risk/existing medical diagnosis.

infectious.			
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End of the report.