# Bupa Care Services NZ Limited - BeachHaven Hospital

## 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bupa Care Services NZ Limited

**Premises audited:** BeachHaven Hospital

**Services audited:** Hospital services - Psychogeriatric services; Hospital services - Medical services

**Dates of audit:** Start date: 26 July 2021 End date: 27 July 2021

**Proposed changes to current services (if any):** The service is also certified for hospital – geriatric care which has not been listed above.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 94

# 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 |
|  | 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

BeachHaven is part of the Bupa group. The service is certified to provide hospital and psychogeriatric levels of care. The service has 99 beds, and on the day of audit there were 94 residents. The service is managed by a care home manager who is a registered nurse. She has been in her role for three years and has worked at BeachHaven as a clinical manager for over twenty years. The care home manager is supported by a clinical manager.

This surveillance audit was conducted against a subset of 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 residents and staff files, observations and interviews with residents, relatives, staff, management and general practitioner.

Systems, processes, policies and procedures are structured to provide appropriate quality care for people who use the service. Implementation is supported through the Bupa quality and risk management programme.

This surveillance audit identified four improvements are required in relation to staff education, RN staffing and medication management.

## 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 the resident’s condition, including any acute changes or incidents. The complaints process is implemented and managed in line with the Code of Health and Disability Consumers’ Rights.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

There are developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who live at Bupa BeachHaven. Quality initiatives are implemented, which provide evidence of improved services for residents. Interviews with staff, and the review of meeting minutes demonstrate staff involvement in the quality and risk management programme.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. There is an in-service training calendar in place.

## 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 medium or high risk and/or unattained and of low risk. |

A comprehensive information booklet is available for residents/families at entry which includes information on the service philosophy, services provided and practices relevant to a psychogeriatric secure unit. The care home manager takes primary responsibility for managing entry to the service with assistance from the clinical manager. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations.

Care plans reviewed are based on the interRAI outcomes and other assessments. Families interviewed confirmed they are involved in the care planning and review process. There is a minimum of a three-monthly resident review by the medical practitioner and psychogeriatric community team as required.

There is a group activity programme. Individual activity plans have also been developed in consultation with family. The activity programme includes meaningful activities that meet the recreational needs and preferences of the psychogeriatric and hospital level residents.

Medicines are stored appropriately. There are regular visits and support provided by the community mental health team and psychogeriatrician.

All meals are prepared on-site. Resident’s individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period.

## 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 building warrant of fitness. A preventative maintenance programme is being implemented. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility.

## 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. |

There is a restraint policy that includes comprehensive restraint procedures. The care home manager is the restraint coordinator. At the time of the audit, seventeen residents were using a restraint and two residents were using an enabler.

## 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. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## 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 | 13 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 2 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | Complaints are being managed in line with Right 10 of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Consumers’ Rights (the Code). Residents (three hospital) and family members advised that they are aware of the complaint’s procedure. Discussions around concerns and complaints were evident in facility meeting minutes. Families interviewed stated that complaints are followed up and the care home manager is very approachable.  A record of complaints, both verbal and written, is maintained by the care home manager using an electronic complaints’ register. There were four complaints on the complaints register for 2021 (year to date) and all four complaints have been resolved.  Two complaints lodged with the Health and Disability Commissioner in 2020 remain open. One complaint is linked to DHB findings. There have been no corrective actions identified. This complaint is under investigation by HDC. The second complaint has resulted in corrective actions being implemented around wound management, including: ensuring the wound management process is following Bupa policy; monitoring the correct use of wound care templates; ensuring staff understand how to sufficiently document wounds in progress notes and when using the Riskman electronic tool; and improving communication between staff regarding wounds (e.g., during handovers). Plans are underway to develop an internal wound management auditing tool. Two meetings with senior RNs have occurred and the target date for completion of this tool is 31 August 2021. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure 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 have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms reviewed identified that family are kept informed. Relatives interviewed (four psychogeriatric [PG]) stated they are kept informed when their family member’s health status changes or if there has been an adverse event.  An interpreter policy and contact details of interpreters is available. Residents and staff identify with a range of different cultures and ethnicities. Families are used in the first instance.  Family/enduring power of attorney (EPOA) are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The information pack is available in large print. The service has developed a pamphlet to give new family members that contains all they need to know about the service and key people. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa BeachHaven is certified to provide psychogeriatric, and hospital (medical and geriatric) levels of care for up to 99 residents. There are 99 beds in total, 27 hospital level beds and 72 psychogeriatric level beds. On the day of audit there were 94 residents: 26 residents at hospital level of care and 68 residents at PG level of care. Four residents were on a long-term support - chronic health conditions (LTS-CHC) contract (three PG and one hospital) and one resident was on ACC (hospital). The remaining residents were on the aged related residential care contract (ARRC).  The service is managed by a care home manager who is a registered nurse and has been in the role since June 2018. The care home manager was the clinical manager at BeachHaven for 20 years prior to accepting the role as care home manager. The clinical manager has been in the role since August 2018. He was a unit coordinator at Bupa BeachHaven prior to this role.  A vision, mission statement and objectives are in place. Progress towards the achievement of annual goals for the facility are regularly reviewed by the care home manager with progress reported in the monthly staff and quality meetings.  Both managers have completed over eight hours of professional development relating to their job role and responsibilities. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff meeting minutes and interviews with staff (four caregivers, eleven RNs, one maintenance, one chef, two activities coordinators) confirm staff are made aware of any new/reviewed policies and are involved in the quality and risk management programmes.  A range of meetings are held including staff meetings, quality meetings, family/resident meetings, infection control and health and safety meetings, restraint meetings and RN meetings. Meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, and audit outcomes. Meeting minutes are posted in the staff room for staff to read. Staff interviewed stated they are well informed and receive quality and risk management information such as a monthly adverse event summary.  The service collates accident/incident and infection control data. Monthly comparisons include trend analysis and graphs. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions to address issues identified from internal audit results and adverse event data results are developed where opportunities for improvements are identified and are signed off by the clinical manager when completed. A corrective action plan to address lower results in the 2020 annual satisfaction survey (when compared to 2019) was completed and shared with families.  Facility acquired wounds (e.g., pressure injuries) have reduced from 15 (May 2020) to 3 (May 2021). Strategies implemented have included the purchase of additional pressure relieving mattresses and cushions, tool box (impromptu) talks at handover, staff training by the DHB wound care specialist, and in services by pressure injury equipment specialists (e.g., Cubro). An internal audit tool to monitor wound management is in the development stage.  There is an implemented health and safety and risk management system in place including policies to guide practice. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings. Contractors are orientated to health and safety processes via reception with additional site orientation provided by maintenance.  Falls management strategies include assessments after falls and individualised strategies including physiotherapist input two days a week (0800 - 1500) with additional support provided by a physiotherapy assistant four days a week (0700 – 1430); updated resident transfer plans; regular toolbox talks, in services and discussions at handover to alert staff to residents who are at risk or who have had a fall; the purchase of perimeter mattresses; and resuming the resident walking group since the pandemic lockdown. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Staff document adverse events electronically (Riskman). The clinical manager reviews all incidents each month and summarises results. Incidents and accidents are trended and benchmarked. This information is shared with staff.  Ten incident forms reviewed identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations are completed for unwitnessed falls and any known head injury.  The caregivers interviewed could discuss the incident reporting process. Staff related incident forms are discussed at the health and safety meeting.  The care home manager interviewed is able to describe situations that would require reporting to relevant authorities. Section 31 reports completed since the previous audit include nine pressure injuries, two suspected outbreaks and one assault. |
| 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. | PA Low | There are human resources policies to support recruitment practices. The register of RNs and ENs practising certificates and external health professionals (e.g., GP, physiotherapist, pharmacy, podiatry, dietitian) is maintained. Seven staff files were reviewed (three RNs, one EN, one maintenance, one cleaner, one kitchen assistant). All files contained relevant employment documentation including a signed employment agreement and job description, and reference checking. Performance appraisals are completed a minimum of annually.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed stated that new staff are adequately orientated to the service on employment, which includes being buddied with more experienced staff. Evidence of completed orientation programmes were sighted in all seven staff files reviewed.  There is an annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. The service provides regular training for staff including impromptu tool box talks. Staff complete competency assessments that are specific to their job role and responsibilities.  Eleven of twenty-two RNs have completed interRAI training. Caregivers are encouraged to complete their Careerforce qualifications although a sample of caregiver staff who have been employed for over eighteen months to work in the PG units have not achieved their required dementia qualification. A first aid trained staff is always on duty (24/7). |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | A policy is in place that determines staffing levels and skill mix for safe service delivery. The staff roster provides sufficient and appropriate coverage for the effective delivery of care and support. Difficulties arise when shifts cannot be filled.  Current staffing levels reflect two full time RN vacancies and two caregiver vacancies. The clinical manager/RN and care home manager/RN are rostered Monday – Friday. The clinical manager had just begun paternity leave for 2.5 months. There are three-unit coordinators/RNs (one hospital, and one for each PG wing (Kowhai and Tui). The care home manager and unit coordinators have been delegated additional responsibilities during the temporary absence of the clinical manager.  There are two PG wings (kowhai and tui) and one hospital wing (east wing):  Kowhai wing- 40 beds (37 residents at PG level of care): The unit coordinator is rostered Monday – Thursday and Saturdays. Two RNs or one RN and one EN are rostered on the AM shift, two RNs are rostered on the PM shift and one RN is rostered on the night shift. Five long (eight hour) and two short shift caregivers (to 1300) are rostered on the AM shift, two long and two short caregivers (1500 – 2130) are rostered on the PM shift and two caregivers are rostered on the night shift.  Tui wing -32 beds (28 residents at PG level of care): The unit coordinator is rostered Monday – Friday. One RN is rostered on the AM shift, one RN on the PM shift and one RN or one EN on the night shift. Four long and two short shift caregivers (to 1300) are rostered on the AM shift, two long and two short (to 2130) are rostered on the PM shift and one caregiver is rostered on the night shift.  East wing -27 beds (26 hospital level residents): A staff RN is rostered on the AM shift seven days a week. The unit coordinator (also a staff RN) works in this role two days a week. One RN or one EN is rostered on the PM shift. One RN or two senior caregivers are rostered on the night shift. Substituting two caregivers for one RN does not meet contractual obligations. Three long and three short (to 1300) caregivers are rostered on the AM shift, two long and one short (1730 – 2130) caregivers are rostered on the PM shift and one caregiver is rostered on the night shift. In addition, a caregiver is rostered from 0700 – 1500 and 1700 – 2100 for specialling of one resident, funded by ACC.  The on-call schedule is the responsibility of the care home manager with a new on-call roster in the process of being implemented by the Bupa organisation where a call roster is shared between facilities.  Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RNs, clinical manager and care home manager but were unsatisfied around staffing levels with staff frequently calling in sick at short notice. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Twelve medication charts were reviewed. There are policies and procedures in place for safe medicine management that meet legislative requirements, however not all crushed medications were documented as such on the electronic medication charts sampled. The medication charts reviewed identify that the GP has seen and reviewed the resident three-monthly.  All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed administering medications. RNs interviewed described their role regarding medication administration. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.  The GP reviews the use of anti-psychotic medication and if required, makes a referral to the psychogeriatrician.  Standing orders are not in use. There are no residents self-medicating.  The medication fridge and room temperatures are recorded regularly, and these are within acceptable ranges. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at Bupa Beach Haven are prepared and cooked on-site. There is a four-weekly seasonal menu with dietitian review and audit of menus. The menu is adapted to ensure resident’s food preferences are considered. Finger foods and snacks are available for residents over a 24-hour period. Meals are prepared in the main kitchen and sent to the wings in temperature-controlled bain-maries. The chef and kitchen staff are trained in safe food handling and food safety procedures are adhered to. Kitchen fridge, food and freezer temperatures were monitored and documented daily; these were within safe limits. Adapted cutlery, sipper cups and lipped plates are available for resident use. Dietary profiles are completed on admission and likes and dislikes and any changes to dietary needs are communicated to the kitchen via the RNs. A dietitian is available on request. Supplements and fortified foods are provided to residents with identified weight loss issues. The chef (interviewed) is familiar with all residents’ likes and dislikes and those residents with specific dietary needs.  Relatives confirmed on interview, that there are always snacks, fruit and sandwiches available for residents to eat and that these platters are replenished regularly by care staff with extra supplies being available in the kitchen. Relatives also report that meals are well presented, and that staff assist those residents who require help with food and fluid intake. The kitchen has a current food control plan in place. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents' care plans continue to be completed by the RNs. When a resident's condition alters, the RN initiates a review and if required, GP or mental health services consultation.  All files have at least an initial physiotherapy assessment with ongoing assessments as necessary. The psychogeriatrician and mental health services are readily available as required. A dietitian and geriatric nurse specialist visit by referral and a podiatrist visit residents regularly.  The family members interviewed stated they are kept informed of the resident’s health status and have the opportunity to meet with the GP or nurse practitioner if required.  Continence products are available and resident files include a urinary continence assessment, bowel management and the continence products that are required are identified.  Adequate dressing supplies are available. Wound management policies and procedures are in place and weights are recorded at least monthly. The wound register currently includes one stage two pressure injury (facility acquired) and two unstageable pressure injuries (facility acquired). Pressure injuries have been entered on to Riskman and section 31 notifications completed for the two unstageable pressure injuries. Other wounds include three chronic ulcers, six skin tears, one dermatitis, two abrasions and one surgical wound. All wound documentation reviewed was fully completed. There was evidence of wound nurse specialist and GP involvement in chronic wound management.  There is a comprehensive range of monitoring forms available for use and these have been completed as needed.  The care team and activities staff interviewed are able to describe strategies for the provision of a low stimulus environment where required. |
| 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 activities coordinator has been at the facility for 29 years, she is supported in the role by three other activities coordinators and a dedicated van driver, all of whom have current first aid certificates. The activities coordinators have completed the dementia standards.  The weekly activities programmes are displayed around the facility on noticeboards. Residents who do not participate regularly in the group activities, are visited for one-on-one sessions. All interactions observed on the day of the audit evidenced engagement between residents and the activity coordinator. There are four levels of activity to guide staff as to which is most appropriate for a particular resident: active able, less active able, less active less able, and limited activity limited ability. The activity program is further broken down into physical, cognitive, creative and social activities.  Each resident has a Map of Life developed on admission. The Map of Life includes previous careers, hobbies, life accomplishments and interests which forms the basis of the activities plan. The resident files reviewed included a section of the long-term care plan for activities, which has been reviewed six-monthly. The care plan includes activity over a 24-hour period which can be used to minimise, distract or de-escalate behaviours.  Relatives interviewed spoke very positively of the activity programme.  In addition to an activities coordinator who works between the three wings, caregivers assist with activities over the weekend and evenings. Care staff were observed at various times through the day diverting residents from challenging or agitated behaviours. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the residents’ files reviewed, all initial care plans have been documented and evaluated by the RN within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. Evaluation includes documenting progress towards the achievement of the intended goals. The multidisciplinary review involves the RN, GP, community mental health team (as required), activities staff and family. The family are invited to attend and/or notified of the outcome. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness which expires on 9 July 2022. Fire equipment is checked by an external provider. The maintenance person interviewed described the reactive and preventative maintenance programme. There is a 52-week planned maintenance programme in place. Electrical equipment has been tested and tagged. Hot water temperature is monitored weekly in resident areas and at hot water cylinders.  The corridors are wide enough around the facility and handrails available to promote safe mobility. Residents were observed moving freely around the facility with mobility aids where required. There are areas to wander inside and outside with secure garden areas extending off both PG units.  There is sufficient equipment available to staff in all areas that is calibrated annually.  There are outdoor areas with seating and shade. There is wheelchair access to all areas. |
| 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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. A unit coordinator (RN) is the infection control coordinator. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Infections are included on a monthly register and a monthly report is completed by the infection control officer. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly. Meeting minutes are made available to staff.  Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Infection control data is collated monthly and discussed at the staff meetings. The infection control programme is linked with the quality management programme.  Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. The majority of residents have received both doses of the Pfizer Covid-19 vaccine with staff vaccination ongoing in conjunction with the local DHB. Residents and staff are offered the influenza vaccine. Covid-19 scanning/manual sign in is mandatory on entry to the facility.  Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and geriatrician that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are documented definitions for restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint policy includes comprehensive procedures. Implementation of restraint use is monitored through internal audits, facility restraint meetings, and at an organisational (head office) level.  At the time of the audit there were two (hospital) residents using bedrails as an enabler and seventeen residents using a restraint (four hospital and thirteen PG). Types of restraints used include bedrails (three) and lapbelt (one) for the hospital level residents; and bedrails (three), intermittent lapbelts (three), low bed (one) and intermittent handholding (six) for the PG level residents. All restraints and enablers are reviewed monthly.  One file reviewed for the use of bedrails as an enabler reflected an assessment, voluntary consent by the resident, regular monitoring for resident safety and monthly reviews. The resident felt that the bedrails assisted in keeping them safe in bed. |

# 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 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | An education programme is in place that includes in service training, impromptu toolbox talks at handovers and competency assessments. A selection of caregivers working in the PG units have not completed the required unit standards within 18 months of employment. | There are 44 caregivers who work in the PG units and 32 have completed the required PG unit standards. Eight are in the process of completing theirs and four caregivers are recently employed and have not enrolled yet. Six of the eight caregivers who are in the process of completing the required standards have been employed longer than18 months. | Ensure all caregivers who provide care for PG level residents complete the required unit standards for working in a PG unit within 18 months.  90 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | Two RN staff vacancies have resulted in difficulties with RN staffing for this 99 bed PG and hospital facility. The care home manager is working towards filling vacancies. In the interim, she states it has been necessary for her to roster two senior caregivers to work in the hospital on the night shift to fill the role on one RN. | i) As per contractual requirements, the hospital wing is required to be staffed with a minimum of one RN 24 hours a day, seven days a week but due to RN staff vacancies, the hospital wing is occasionally staffed with two senior caregivers on the night shift when an RN is not available. For example, during the week of 18 - 24 July 2021, two senior caregivers covered the night shifts instead of one RN for five of seven nights. | Ensure the hospital wing is staffed with a minimum of one RN 24 hours a day, seven days a week.  60 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | There is a policy in place for the use of crushed medications. Not all crushed medications were given according to the policy. | Three of the twelve medication charts did not include the direction to crush medication although these were crushed prior to administration to the resident. One resident whose medication chart indicated medications to be crushed was given the medication whole. | Ensure that the use of crushed medications is according to policy.  60 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.