# Bupa Care Services NZ Limited - Gladys Mary Rest Home

## Introduction

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

The audit has been conducted by 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:** Gladys Mary Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 20 October 2021 End date: 21 October 2021

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 35

# 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** |
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|  | 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

Gladys Mary Rest Home is part of the Bupa group. The service is certified to provide rest home and dementia level care for up to 39 residents. There were 35 residents on the day of audit.

This unannounced surveillance audit was conducted against a subset of the relevant Health and Disability services 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.

The service is currently managed by a relief care home manager who is a registered nurse. She has been at the facility since May and has worked for Bupa approximately a year. She has an extensive background in aged care and management both in New Zealand and overseas. The care home manager is supported by a clinical manager who has been in the role for two years and has a background in mental health and spark of life.

The service has addressed on of the two shortfalls around quality data. Further improvements continue to be required around water storage. This audit identified further shortfalls around self-administration of medication and interRAI assessments.

## Consumer rights

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| 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

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| 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. |

There are developed systems, processes, policies and procedures that are structured to provide appropriate quality care for people who live at Bupa Gladys Mary. Quality initiatives are implemented, which provide evidence of improved services for residents. Interviews with staff, and the review of meeting minutes demonstrated 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

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

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. Care plans guide staff in the safe delivery of care to residents. The care plans are personalised, and goal orientated. Care plans are reviewed every six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months.

The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. The programme encourages the maintenance of community links. There are regular entertainers, outings, and celebrations.

Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and accommodated. All meals and baking are cooked on site. This includes consideration of any particular dietary preferences or needs. There is a four-week rotational menu that is reviewed by a dietitian. Nutritional snacks are available 24 hours.

## Safe and appropriate environment

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

The building has a current warrant of fitness. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services.

## Restraint minimisation and safe practice

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| 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 clinical manager (RN) is the restraint coordinator. At the time of the audit there were no residents were using a restraint and no residents were using an enabler.

## Infection prevention and control

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| 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. There have been three outbreaks since the previous audit, all of which were reported and managed appropriately.

## Summary of attainment

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

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| **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 | 14 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 43 | 0 | 2 | 1 | 0 | 0 |

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| **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).

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| **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 (two rest home) and family members interviewed 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 and clinical manager are both very approachable.A record of complaints, both verbal and written, is maintained by the care home manager using an electronic complaints’ register. There were two complaints on the complaints register for 2021 (year to date) and both complaints have been resolved in a timely manner. There have been no complaints from external providers since the last audit. |
| Standard 1.1.9: CommunicationService 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 (two rest home and one dementia) 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. 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 and has specific information relating to the dementia level care unit. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bupa Gladys Mary is certified to provide dementia and rest home levels of care for up to 39 residents. On the day of audit there were 35 residents: 21 at rest home level and 14 residents at dementia level of care. All residents were on the age-related residential care contract (ARCC).The service is managed by a relief care home manager who is a registered nurse and has been at the facility since May 2021. The care home manager has previously worked as an RN, clinical manager and relief manager at other sites. The clinical manager has been in the role since 2019. She worked in mental health for the DHB 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 relief 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 SystemsThe 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, one RN, one maintenance, two kitchen staff, and one administrator) confirmed 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 staffroom 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. 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 (as required). 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 shortfalls identified at the previous audit related to data analysis and communication to staff have been resolved. |
| 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 relief care home manager interviewed is able to describe situations that would require reporting to relevant authorities. Section 31 reports completed since the previous audit included one attempted break-in, one absconder, three outbreaks and one unstageable pressure injury. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resources policies to support recruitment practices. The register of RNs and external health professionals practising certificates (e.g., GP, physiotherapist, pharmacy, podiatry, dietitian) is maintained. Five staff files were reviewed (one RN, one clinical manager, two caregivers [one dementia unit], and one activities 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 five 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. All three RNs (including the clinical manager) have completed interRAI training. Caregivers are encouraged to complete their CareerForce qualifications and all who work in the dementia unit have achieved the required unit standards. Across all caregivers employed, seven have achieved lever 4, six level 3, four level 2 and there are no level 0. Additionally, the activities assistant has achieved the required unit standards necessary to work in the dementia level care unit. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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. Staff interviewed confirmed the service attempts to fill vacant shifts and described difficulties on occasion when shifts cannot be filled at short notice. The clinical manager/RN and care home manager/RN are rostered Monday – Friday. The RNs work 0645-1515 on a four on – two off roster, meaning there are days when there are two RNs on shift plus the clinical manager. An enrolled nurse (EN) also works 0645-1515 two days per week plus fills in as required to provide assistance to the RN during GP rounds and paperwork days. In the dementia unit there is either an RN, EN or level four caregiver as team leader during the morning shift. They are supported by two caregivers on morning shifts in the rest home (0645-1515) and two on the same hours in the dementia unit. In the afternoon there are two caregivers in the rest home (1445-2300) and two in the dementia unit (one 1330-2130 and one 1445-2300). There are two caregivers working 2245-0700 overnight covering both rest home and the dementia unit between them. The on-call schedule is shared between facilities in the region, with a clinical manager and a care home manager being available 24/7. Residents and relatives stated there were adequate staff on duty at all times.  |
| 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 Low | Ten medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. All clinical staff (RNs, EN and senior caregivers) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses and caregivers interviewed could describe their role regarding medication administration. The service currently uses robotics for regular medication and ‘as required’ medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication rooms. The medication fridge and medication room temperatures are monitored daily, and the temperatures were within acceptable ranges. All medications are checked weekly and signed on the checklist form. All eyedrops have been dated on opening. Two residents were self-medicating on the day of audit and had safe and secure storage in their room. Self-medication assessments were in place authorised by the GP; however, these were not consistently reviewed within the required timeframes.The GP reviews the use of antipsychotic medication and if required, makes a referral to the psychogeriatrician. Standing orders are not in use.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at Bupa Gladys Mary are prepared and cooked on site. There is a food control plan expiring September 2022. Kitchen staff are trained in safe food handling. Staff were observed to be wearing correct personal protective clothing. End-cooked and serving temperatures are taken on each meal. Chiller and freezer temperatures are taken daily and are all within the accepted ranges. Cleaning schedules are maintained. All foods were date-labelled in the pantry, chiller and freezers. Resident meetings, surveys and one-to-one interaction with kitchen staff in the main dining room allow the opportunity for resident feedback on the meals and food services generally. 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 dementia unit in a temperature-controlled bain marie. 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 cook (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. Relatives also reported that meals are well presented, and that staff assist those residents in the dementia unit who require help with food and fluid intake. |
| 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 are completed by the RNs. When a resident's condition alters, the RN initiates a review and if required, GP or mental health services consultation. A physiotherapist, dietitian and wound nurse specialist are available by referral and a podiatrist visits residents regularly. The older persons’ mental health team are readily available as required. The family members interviewed stated they are kept informed of the resident’s health status and have the opportunity to meet with the GP 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 two chronic ulcers and two skin tears. There are no current pressure injuries. 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 were able to describe strategies for de-escalation and the provision of a low stimulus environment where required. |
| Standard 1.3.7: Planned ActivitiesWhere 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 | An activity coordinator works 8.30 am to 3 pm Monday to Friday, across the rest home and dementia communities. The activities coordinator is currently undertaking the diversional therapy qualification and attends regional diversional therapy meetings. The service is currently recruiting for an activity assistant to provide cover for six hours a week over three days. These times are currently covered with care staff assisting with activities. There are separate activity programmes for the rest home and dementia care with integrated activities such as exercises, ball games, happy hours with music and entertainment, pet therapy and church services. There are resident-led activities in the rest home including sing-alongs, quizzes, and board games as observed on the day of audit. Caregivers incorporate activities in their role in the dementia care community with oversight from the activity’s coordinator. A quiet/family/whānau room has been designated in the dementia community with memorabilia and activity resources available for residents, staff and family. Activities are offered to meet the cognitive, physical, intellectual and emotional needs of the residents. On the days of audit, residents in both areas were observed being actively involved in a variety of activities with support and involvement of staff. The programme is developed monthly and displayed throughout the facility. The weekly drives/outings for dementia care residents and twice weekly for rest home residents to places of interest are currently temporarily suspended due to Covid restrictions. There are regular entertainer visits. An activity profile and “Map of Life” is completed on admission in consultation with the resident/family (as appropriate). Socialising and activity plans were incorporated into the long-term care plan and reviewed six monthly at the same time as the care plans. Resident meetings are held monthly, and residents reported that they are satisfied with the variety of activities offered. The residents and families interviewed spoke positively about the activities programme. |
| 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 are 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 1 November 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 with 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 the dementia unit. 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.Improvements since the previous audit include general refurbishments to the nurse’s station in the rest home and an ongoing painting programme within the facility as seen on the days of audit. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | PA Moderate | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills are scheduled every six months. The orientation programme and annual education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes. A civil defence plan is documented for the service. There are adequate food supplies available in the event of a civil defence emergency, however the shortfall in the amount of potable water identified at the last audit still does not comply with the Hawkes Bay DHB requirements. The shortfall identified at the previous audit remains. Residents were observed in their rooms with their call bell alarms in close proximity. There is a minimum of one staff available 24/7 with a current first aid/CPR certificate on all shifts, including night shift. The shortfall identified at the previous audit has been addressed.  |
| Standard 3.5: SurveillanceSurveillance 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. The infection control officer (clinical manager) 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.One Covid and one gastro outbreak occurred in 2020, and one RSV outbreak affecting six residents and one staff member occurred in July 2021. All were reported to public health, contained and managed appropriately.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 and the use of face masks is required as part of level 2 restrictions.Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP and internal Bupa infection control specialist who 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 minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the restraint coordinator (clinical manager), RN and care staff confirmed their understanding of restraints and enablers. At the time of the audit, the service had no residents using any restraints or enablers. Bupa Gladys Mary is classed by Bupa as being restraint free, having had no restraints or enablers for at least six months. Staff training is provided around restraint minimisation and management of challenging behaviours. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.5The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | Policies are in place to safety manage self-administration medication reviews. Self-administration assessments and reviews had been completed; however, this had not occurred consistently within the three-month review schedule as detailed in policy.  | Three monthly GP reviews for self-administration of medications could not be consistently evidenced within the required timeframes for two of two self-administering residents.  | Ensure all self-administration medication reviews are completed at least three monthly and that this is clearly evidenced.90 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | The service has documented and contractual timeframes for the completion of resident assessments. Not all interRAI assessments were completed within the required timeframes. | Four of five resident files reviewed had not had interRAI assessments completed six monthly. | Ensure all interRAI assessments are completed within the required timeframes.90 days |
| Criterion 1.4.7.1Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Moderate | Emergency training for staff begins during their orientation to the service and continues annually with six-monthly fire evacuation drills. There are adequate food stores, however additional water storage is required. The risk rating has been raised from low at the previous audit to moderate.  | Currently the facility has the equivalent of three litres of emergency water (bottles expired 22/08/21) stored on site per person per day for three days. The requirement for the Hawkes Bay DHB area is that the amount of potable water available for emergency situations be three litres per resident for ten days (1170 litres). The purchase and installation of a 1000 litre tank which was to be arranged following the last audit has not yet been actioned.  | Ensure that there is a minimum of three litres of water per resident per day for ten days in the event of a civil emergency.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.

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| No data to display |

End of the report.