Queenstown Country Club Living Well Limited - Lake Wakatipu Care Centre

Introduction

This report records the results of a Provisional 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:

Legal entity:	Queenstown Country Club Living Well Limited
Premises audited:	Lake Wakatipu Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 6 April 2021 End date: 7 April 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: 32

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.

General overview of the audit

Lake Wakatipu is part of the Bupa group. The service is certified to provide hospital (medical and geriatric) and rest home level care for up to 35 residents. On the day of audit there were 32 residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owners. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, general practitioner, staff and management.

The service is currently managed by a care home manager who is a registered nurse. The care home manager has been in the role since May 2017. She is supported by an experienced clinical manager who has been in the role since May 2017. Residents, relatives, and the GP interviewed were complimentary of the service provided.

The prospective purchaser is a national health and disability provider for elderly care services. The prospective purchaser reported the current policies, systems and staff will remain in place following the purchase in the short term. Once the new owner's management team is in place then the new owner's policies and procedures will be implemented. The current care home manager will continue to provide support to the new owners until a new senior team is in place.

This audit identified six areas for improvement around: complaints documentation, meeting minutes, staffing, monitoring of care and environmental improvements.

Consumer rights

Lake Wakatipu continues 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. 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. Evidence-based practice is apparent, promoting and encouraging good practice. 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

Lake Wakatipu has an established quality and risk management process in place that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including quality meetings. An annual resident/relative satisfaction survey is completed and there are quarterly resident/relative newsletters. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Interviews with staff and review of meeting minutes/quality action forms/toolbox talks, demonstrated a culture of quality improvements. 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. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. A sample of residents' files validated the service delivery to the residents. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. Planned activities are appropriate to the resident groups. The residents and family interviewed confirmed satisfaction with the activities programme. Staff responsible for medication management have current medication competencies. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met where required.

Safe and appropriate environment

The building has a current warrant of fitness. Staff are provided with personal protective equipment. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids or lazy boy chairs. The hallways and communal areas are spacious and accessible. All bedrooms are single, and some have shared ensuite facilities. The outdoor areas are safe and easily accessible. Housekeeping staff maintain a clean and tidy environment. Laundry and linen service is completed off site with personals completed onsite.

There is an approved evacuation scheme and sufficient emergency supplies for at least three days. A staff member trained in first aid is on duty at all times.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place. At the time of audit, there was one resident with restraint and two residents using an enabler. The assessment and consent were completed for the enabler. Staff receive training

in restraint minimisation and challenging behaviour management. Assessment, intervention and evaluation was in place for the resident with restraint.

Infection prevention and control

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 (registered nurse) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training provided by Bupa head office and external training provided by the local DHB. There is a suite of infection control policies and guidelines available electronically to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with other Bupa facilities. There have been no outbreaks since the previous audit.

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	45	0	4	1	0	0
Criteria	0	96	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. The care home manager, clinical manager and twelve staff interviewed (four registered nurses, five caregivers, one cook, one activities person and one maintenance) could describe how the Code is incorporated into their job role and responsibilities. Staff receive training on the Code during their induction to the service. This training continues via the staff education and training programme. Interview with the prospective purchaser (The head of special projects for Arvida) confirmed that the prospective owners (Arvida) have a good understanding of implementation of the code of resident rights.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed	FA	There are policies around informed consent. Six resident files reviewed, four at hospital level, and two at rest home level included signed general consent forms. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is

choices and give informed consent.		an advance directive policy. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files seen. Copies of EPOAs were on resident files where available.
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 on advocacy support services 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 as part of the Bupa training plan.
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 can participate in as much as they can safely and desire to do. Resident/family meetings are held monthly, and quarterly newsletters are provided to residents and relatives.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	The complaints procedure is provided to residents and relatives on entry to the service. The care home manager maintains a record of all complaints, both verbal and written, by using a complaint register in RiskMan. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. The RiskMan complaints log documents a high level of complaints. On review it was noted the service has logged all issues raised (complaints, feedback, and some incidents) as complaints. The manager has a

		policy of proactive logging of complaints. There were 35 complaints logged for 2020 and 11 year to date for 2021. The majority of the complaints were from three family's complainants. The service has a process of offering regular meetings with this (and other families) on a regular basis to try and resolve concerns. Six complaints received during 2021 were reviewed with evidence of appropriate follow-up actions taken. Documentation reviewed reflected the service is proactive in addressing complaints. Feedback is provided to staff and toolbox talks were completed where required. Closure letters to the complainants were not consistently documented. One DHB complaint for 2020 around palliative care has been followed up and closed by the Health and Disability commissioner. There was evidence of palliative training for staff prior to the complaint and as per the Bupa schedule and following the complaint. Six resident files all included oral care. Mouth care resources were available to staff including mouth care resources specifically for palliative residents.
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, the clinical manager and RNs discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the monthly resident/family meetings lead by a representative from Age Concern. Four residents (two rest home and two hospital) and three relatives (three rest home) 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.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and	FA	The residents' personal belongings are used to decorate their rooms. The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when care is being given and do not hold personal discussions in public areas. Caregivers reported that they promote the residents' independence by

independence.		encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected. Shared toilets include appropriate door locking mechanisms. Guidelines on abuse and neglect are documented in policy. Staff receive regular education and training on abuse and neglect, which begins during their induction to the service.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	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 were no residents who identify as Māori living at the facility. Māori consultation is available through the documented iwi links and local Māori advocates (Nga Kete Matauranga Pounamu).
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs and desires from the time of admission. Beliefs and values are incorporated into the residents' care plans, evidenced in all care plans reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Code of conduct training is also provided through the in-service training programme. 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Evidence-based practice is evident, promoting and encouraging good practice. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. Policies and procedures have been reviewed and updated at organisational level and are available to staff. There are clear ethical and professional standards and boundaries within job descriptions. Registered nursing staff are available 24 hours a day, 7 days a week. The contracted medical practice ensures the GP visits once a week or as needed. The hospital is co-located to the service. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. Physiotherapy services are provided on site, once a week. The service has links with the local community. Relatives interviewed spoke positively about the care and support provided. Bupa has robust quality and risk framework. The framework includes standardised policies; an education programme including core competencies for different staff groups; an internal audit and corrective action planning process; benchmarking against similar services types; centralised management of complaints and internal investigation following category one incidents; and surveys (resident/relative and staff). The Bupa quality framework is being implemented at Lake Wakatipu apart from the meeting's documentation (link 1.2.3.8).
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed understood about open disclosure and providing appropriate information when required. Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Ten accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.

		An interpreter service is available and accessible if required through the district health board. Staff and family are used in the first instance.
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 Lake Wakatipu provides rest home and hospital (geriatric and medical) level care for up to 35 residents. All beds are dual-purpose. At the time of the audit there were 32 residents in total. There were eight rest home residents, including one resident on an ACC funded contract and 24 hospital residents, including one resident on respite and one funded as a palliative care resident. All other residents were under the aged related residential care (ARRC) contract. A vision, mission statement and objectives are in place. Annual quality/health and safety goals for the facility have been determined and are regularly reviewed by the care home manager. A quarterly report is prepared by the care home manager and provided to the Bupa clinical service improvement team on the progress and actions that have been taken to achieve the Lake Wakatipu quality goals. Lake Wakatipu has identified two goals for 2021 including reducing falls and encouraging registered nurses to complete the DHB PDRP programme. The service is managed by a care home manager who is a registered nurse. The care home manager has been in the role since May 2017 and has been at Bupa since 2015, previously working in the clinical manger role. She is supported by an experienced clinical manager who has been in the role since May 2017 and has been at Bupa since 2014. The management team is supported by an operations manager who was present at the time of the audit. The care home manager has maintained at least eight hours annually of professional development activities related to managing a hospital. The prospective purchasers are a national provider of health and disability services for older people. There is an in-depth transition plan developed in consultation with the current owners that will allow for a seamless transition for residents and staff. A new service manager who is currently employed by Arvida, will take over the managers role, with the existing Bupa care home manager undertaking the clinical manager role. Arvida are recruiting for a clinical manager. A Bupa relief manager will also assist with the transition. Once all new senior staff have been

		recruited, the Bupa clinical manager and the Bupa relief manager will leave. Arvida have a business plan and quality and risk plan developed specific to Lake Wakatipu. It is anticipated that existing Bupa processes will remain in use until all new senior staff have been employed. Once this is achieved the plan is to introduce the Arvida policies and procedures. Arvida are in the process of building a new care centre in Queenstown, and once built, all residents will transition to the new care centre at the Queenstown Country Club Village (Arvida). Relevant authorities have been notified of the pending change of ownership. The prospective owners have been in contact with the portfolio manager for the DHB. The tentative date of sale is 30 April 2021.
Standard 1.2.2: Service Management 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.	FA	A clinical manager who is employed full-time, supports the care home manager and steps in when the care home manager is absent. The operations manager, who visits regularly, supports both managers.
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.	PA Low	There is a documented quality and risk management process. Interviews with the managers and staff reflected their understanding of the quality and risk management systems. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data collected for a range of adverse event data (eg, skin tears, falls [witnessed and unwitnessed]

		and infections) is analysed. An internal audit programme is being implemented. Corrective actions developed for areas identified for improvements (eg, complaints management, manual handling, infection control) indicate that these corrective actions have been successfully resolved. Staff are informed of quality results via staff meetings and handovers. Not all meeting minutes reviewed documented that issues raised during meeting were documented as followed up in subsequent meetings, meeting minutes did not always document a person responsible and timeframe for follow-up as per the meeting template. There is a designated health and safety officer who is supported by a health and safety representative/HCA. Staff health and safety training begins during their induction to the service and includes a self-learning/competency package. Health and safety is a regular topic covered in the staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. Contractors are orientated to the service as per the Health and safety policy. Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. Interview with the prospective purchasers confirmed the current quality management system and performance monitoring programme will continue following the sale until a new senior team is fully employed. Following this the Arvida policies and processes will be introduced. Arvida have purchased many services and have a robust plan to transition to their processes.
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	Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. All incidents are coded in severity on RiskMan (severity 1-4) with 4 being the most severe. All resident incidents logged with a severity of 3 or 4 are automatically escalated to the Bupa CSI team immediately and the operations manager. Actions are then followed up and managed.

		Ten accident/incident forms were reviewed; each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observation forms were documented and completed for any unwitnessed falls with a potential head injury. Interview with the prospective purchaser confirmed there are no legislative compliance issues that would affect the service.
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	Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Seven staff files were randomly selected for review (three caregivers, three registered nurses and one cook). Files included evidence of the recruitment and induction process, including reference checking, signed employment contracts, job descriptions and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice that is specific to the position. Staff interviewed stated that new staff were adequately orientated to the service. An education and training programme is provided for staff with very high attendance rates (80-90%). Competencies are completed specific to worker type and include (but are not limited to) medication, fire evacuation, resident care and handwashing. A register of current practising certificates for health professionals is maintained. Six of eight RNs have completed their interRAI training. A first aid trained staff is always available 24/7, including on outings. Training around palliative care has included: end of life care and prescribing and also syringe driver competencies for RNs (March 2021). Caregiver training has included managing complaints (communication), observing and reporting deteriorating residents, mouth care and swallowing (all June 2021).
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 for determining staffing levels and skills mix for safe service delivery. Adequate RN cover is provided 24 hours a day, 7 days a week. Sufficient numbers of caregivers to support the RNs are rostered, but not always available for the shift. Staff on the floor on the days of the audit were visible and were attending to call bells in a timely

		manner. Caregivers interviewed stated that management are supportive and approachable. Staff interviewed advised that there are not always sufficient staff on duty at all times and that staff replacements due to sickness/absenteeism are not always filled. The care home manager and clinical manager work from Monday to Friday and are available on-call after hours. All beds in the facility are dual purpose. At the time of the audit there were 32 residents in total (eight rest home residents and 24 hospital residents). The roster includes: On the morning shift, there is one RN and six caregivers on duty: (four full shifts, plus one 7 am to 1.30 pm and one 7 am to 2.30 pm). On the afternoon shift there is one RN and five caregivers: (two 3 pm to 11 pm and three 4.30 pm to 10.30 pm). On the night shift there is one RN and one caregiver. Residents and family members interviewed reported that there are not always adequate staff numbers to attend to residents. Interview with the prospective purchaser confirmed there are no plans to change the roster in the short term although current staffing shortfalls will be addressed. (Noting that the staffing roster for the purchaser is based on a wellness model and the roster will structure differently in the long term. The newroster structure will be similar to other Arvida care centres).
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident 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. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation.

Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There is an implemented Bupa admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The care home manager and clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment and the entry screening process. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The six admission agreements reviewed meet the requirements of the ARRC and were signed and dated. Exclusions from the service are included in the admission agreement. Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the care home manager or clinical manager are available to answer any questions regarding the admission process.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a policy that describes guidelines for death, discharge, transfer, documentation and follow-up. A record is kept and a copy of which is kept on the resident's file. All relevant information is documented on the Bupa transfer form and accompanied with a copy of the resident admission form, most recent GP consultation notes and medication information. Resident transfer information is communicated to the receiving health provider or service using the yellow envelope system. There is documented evidence of family notification of appointments and transfers. Relatives interviewed confirmed that they are notified and kept informed of the resident's condition. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family is made.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are 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 legal requirements had been met. There are no standing orders in use. There are no vaccines stored on site. All clinical staff (RNs and one EN) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses have completed syringe driver training. Staff were observed to be safely administering medications. Registered nurses 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 room. The medication fridge and medication room temperature are monitored daily, and the temperatures were within acceptable ranges. All medications including the bulk supply order is checked weekly and signed on the checklist form. All eyedrops have been dated on opening. Staff sign for the administration of medications electronically using an electronic system. Twelve electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted. Those resident's requiring medications to be crushed had clear indications and instructions documented by the prescriber on their medication charts.
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	A kitchen manager oversees the on-site kitchen, and all meals are cooked on site. There is a seasonal four-week rotating menu, which is reviewed by a dietitian at organisational level. A resident nutritional profile is developed for each resident on admission which identifies dietary requirements and likes and dislikes, and this is provided to the kitchen staff by registered nurses. The kitchen is able to meet the needs of residents who require special diets, and the cook works closely with the registered nurses on duty. Special diets and likes and dislikes

		are readily visible on a whiteboard in the kitchen and are updated with any changes to match updated nutritional profiles. Special equipment such as lipped plates and adapted cutlery are available according to resident need. On the day of audit, meals were observed to be well presented. Supplements are provided to residents with identified weight loss issues. Additional snacks are available at all times. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring September 2021. 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 acceptable range. Cleaning schedules are maintained. All foods were date labelled in the pantry, chiller and freezers. 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. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. 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.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The service uses the Bupa assessment booklets and person-centred templates (My Day, My Way) for all residents. The assessment booklet includes falls, Braden pressure area, skin, mini nutritional, continence, pain (verbalising and non-verbalising), activities and cultural assessment. These are completed on admission and reviewed six-monthly as part of the evaluation unless

		changes occur prior, in which case a review is carried out at that time. InterRAI assessments had been completed for all long-term residents' files reviewed. Areas triggered were addressed in the care plans reviewed. Initial interRAI assessments and reviews were evident in printed format in all resident files.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Six resident files were reviewed across a range of conditions including (but not limited to) end of life care, communication, diabetes, dementia, behaviour that challenges and choking risk. In all files reviewed the care plans were comprehensive, addressed the resident need and were integrated with other allied health services involved in resident care. Service integration was evidenced by documented input from a range of specialist care professionals, including the speech and language therapist, dietitian, and mental health care team for older people. Relatives and residents interviewed all stated they were involved in the planning of resident care. In all files reviewed there is evidence of resident and relative involvement in care planning. Activity assessments were completed by the activities staff within three weeks of admission. Care plans reviewed provided evidence of individualised support. Short-term care plans are in use for short-term needs and changes in health status. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	The registered nurses complete care plans for residents. Progress notes in all files reviewed had detailed progress which reflected the interventions detailed in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative's health status, and this was confirmed by family members interviewed, who stated they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident

		health status was viewed in the resident files sampled on the family/whānau contact form. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is employed to assess and assist residents' mobility and transfer needs. Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. There were 18 ongoing wounds including four chronic wounds, eleven skin tears, two haematomas and one blister. There was evidence of wound nurse specialist involvement in chronic wound management. Continence products are available and resident files include a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit. Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring, however, not all monitoring was consistently documented as completed. Care plans have been updated as residents' needs changed. The GP interviewed was complimentary of the service and care provided.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs an activity coordinator and one activity assistant covering Monday to Sunday between them, planning and leading activities in the home. There are set Bupa activities including themes and events which the activities team add to in order to individualise activities to resident need and preferences within the facility. A weekly activities calendar is distributed to residents, posted on noticeboards and is available in large print. On the days of audit residents were observed participating in activities. The activities coordinator seeks verbal feedback on activities from residents and families to evaluate the effectiveness of the activity programme, enabling further adaptation if required. Residents interviewed were positive about the activity

		programme. Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. There are weekly outings to places of interest in the community and there are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, Anzac Day and other cultural festive days are celebrated. There are visiting community groups such as church groups, arts and crafts group, IT assistance and reiki therapy. The activity team provide a range of activities which include (but are not limited to) exercises, Pilates, crafts, games, quizzes, entertainers, cooking and bingo. The activity team are involved in the admission process, completing the initial activities assessment, and have input into the cultural assessment, 'map of life' and 'my day my way' adding additional information as appropriate. An activities plan is completed within timeframes, a monthly record of attendance is maintained, and evaluations are completed six-monthly. Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities according to their preferences. Residents interviewed stated their satisfaction with the activities provided and complimented the members of the activities team.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Long term care plans are evaluated by the RNs six monthly or earlier if there a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six monthly multi-disciplinary review (MDR) is also completed by the registered nurse with input from caregivers, the GP, the activities coordinator, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute

		and short-term issues. These are evaluated at regular intervals.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referrals to other health and disability services were evident in the sample group of residents' files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. Examples of referrals sighted were to occupational therapist, physiotherapy, dietitian, mental health services, speech language therapist, community mental health nurse, and hospital specialists. Discussions with the clinical manager and two registered nurses identified that the service has access to GPs, ambulance/emergency services, allied health, dietitians, physiotherapy, continence and wound specialists, and social workers. The local hospital including an emergency department is located within the same building with medical practitioner cover available at all times.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies and documented processes regarding chemical safety and waste disposal in place. All chemicals were clearly labelled with manufacturers' labels and stored in locked areas. Safety datasheets and product sheets are available and readily accessible for staff. Sharp's containers are available and meet 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 and were seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	The building holds a current building system status report in lieu of a building warrant of fitness, issued January 2021. A request book for repairs is maintained and signed off as repairs are completed, however it is apparent that not all maintenance issues have been reported as requiring action. There is a part-time maintenance contractor who carries out the 52-week planned maintenance programme. The maintenance contractor is also on call after hours for urgent matters. The checking and calibration of medical equipment including hoists, has

		been completed annually and is next due August 2021. All electrical equipment has been tested and tagged; however, some are out of the prescribed date range for retesting. Hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is safe access to all communal areas. The external areas are landscaped and accessible. The caregivers and RNs interviewed stated that they have all the equipment required to provide the care documented in the care plans. The prospective purchaser has no plans for making environmental changes to Lake Wakatipu and will work with the existing provider to address issues raised through this audit. There are long term plans to move to a new building. This is documented in the transition plan.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	Six resident rooms have shared ensuites. There are three communal showers, one bathroom and six communal toilets throughout the facility. Resident rooms have hand basins. Visual inspection evidenced toilet and shower facilities are of an appropriate design to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Handrails are appropriately placed in ensuite bathrooms, communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant. Residents interviewed reported their privacy is maintained at all times.
Standard 1.4.4: Personal Space/Bed Areas	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility equipment.

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		Residents are encouraged to personalise their bedrooms with personal belongings as viewed on the day of audit. Staff interviewed reported that they have more than adequate space to provide care to residents.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are large and small communal areas. Activities occur in all lounges and dining areas which are large enough to cater for the activities on offer, are accessible and can accommodate the equipment required for the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The lounge and dining areas are spacious, inviting and appropriate for the needs of the residents. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance during the audit.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The majority of laundry is undertaken off site, with only personal clothing being washed in the small, well organised laundry. The laundry is divided into a “dirty” and “clean” area and staff could describe how this is managed. There is a comprehensive laundry manual; cleaning and laundry services are monitored throughout the internal auditing system and the resident satisfaction surveys. There is a cleaning manual available. The cleaners’ equipment was attended at all times or locked away in the cleaners’ cupboard. All chemicals on the cleaner’s trolley were labelled. Sluice rooms were kept locked when not in use. Cleaning products are colour coded (eg, mop heads for each area). Personal protective equipment is available in the laundry, cleaning and sluice room. Staff were observed to be wearing appropriate protective wear when carrying out their duties.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during	FA	There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence or other

emergency and security situations.		emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food and supplies (torches, radio and batteries), emergency power and barbeque. The service has alternative gas facilities for cooking in the event of a power failure, with a back-up system for emergency lighting including a back-up generator. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. Smoke alarms, a sprinkler system, evacuation notices and exit signs are in place. The civil defence kit is checked monthly. There is sufficient water stored to ensure for three litres per day for three days per resident stored in an external tank. Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on staff pagers and also give an audible alert. There is an escalation system in place that alerts management should call bells ring for extended periods. Residents have call bells within reach (sighted) and this was confirmed during resident and relative interviews. The service has a visitors' book at reception for all visitors, including contractors, to sign in and out. Access by public is limited to the main entrance. Covid-19 sign-in is mandatory for visitors and staff. Security policies and procedures are documented and implemented by staff. The buildings are secure at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms and communal areas are appropriately heated, have ample natural light and ventilation. The facility has central heating that is thermostatically controlled. Additional large panel heaters are in use in the lounges. Staff and residents interviewed, stated that this is effective. All bedrooms and communal areas have at least one external window. There is one monitored outdoor area where residents may smoke. All other areas are smoke free.

Standard 3.1: Infection control management 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.	FA	The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control coordinator (ICC) is responsible for infection control across the facility as detailed in the ICC job description (signed copy sighted on day of audit). The ICC oversees infection control for the facility, reviews incidents on RiskMan and is responsible for the collation of monthly infection events and reports. The infection control committee and the Bupa governing body are responsible for the development and review of the infection control programme. Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There have been no outbreaks since the previous audit. Covid-19 education has been provided for all staff, including hand hygiene and use of PPE.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at Bupa Lake Wakatipu. The ICC liaises with the infection control champions on the staff who all contribute to the weekly clinical review and quarterly quality meetings. Information is further shared as part of staff meetings and also as part of the registered nurse meetings. The ICC has completed online training in infection control. External resources and support are available through the Bupa quality & risk team, external specialists, microbiologist, GPs and nurse practitioners, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by Bupa head office. The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or have been in contact with infectious diseases. Alcohol based hand gel is available throughout the facility.
Standard 3.3: Policies and procedures	FA	The infection control policies include a comprehensive range of

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		standards and guidelines including defined roles and responsibilities for the prevention of infection, the infection control coordinator, and training and education of staff. Infection control procedures developed in respect of care, the kitchen, laundry and housekeeping incorporate the principles of infection control. Policies are updated regularly and directed from Bupa head office.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICC is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff, and staff have completed infection control education in the last 12 months. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice, education packages and group benchmarking. The ICC has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.
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	Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Bupa surveillance policy. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, and preventative measures put in place. These, along with outcomes and actions are discussed at the monthly infection control conference calls. Meeting minutes are available to staff. Infections are entered into the electronic database (RiskMan) for benchmarking. Corrective actions are established where trends are identified. 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	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. At the time of the audit there was one with a T-belt restraint and two residents using bedrail enablers. Two files were reviewed for restraint and enabler processes: one for an enabler (a bed rail) and one for a restraint (a T-belt). Both files documented an assessment and a consent form. The enabler resident had requested the bedrails. The resident's care plan documented the bedrails, risks and monitoring needs. Progress notes documented that staff monitored the resident as per the care plan and Bupa policy/ Staff receive training on restraint minimisation, which includes testing their competency. The caregivers interviewed were able to describe the difference between an enabler and a restraint.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	A restraint approval process is in place. Restraint minimisation policies and procedures describe approved restraints including environmental restraint. Two registered nurses are the designated restraint coordinators. They are knowledgeable regarding this role.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint coordinators are responsible for assessing a resident's need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool is being implemented. One resident file where restraint was being used was reviewed. This resident's file included a restraint assessment, which included the identification of any risks associated with the use of the restraint. Restraint use was linked to the resident's care plan.

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is in place. The register identifies any residents using a restraint or enabler, and the type of restraint used. The restraint assessment reviewed identified that restraint is being used only as a last resort. The frequency of monitoring residents while on restraint, is documented. Monitoring forms are completed when the restraint is put on and when it is taken off. There have been no adverse events reported as a result of restraint use.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is reviewed six-monthly by the restraint coordinator, meeting requirements of the standard. Each individual resident with restraint is reviewed monthly and restraint is discussed in the clinical review meetings. There are also three-monthly reviews by the GP.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	There are six-monthly teleconferences as part of the overarching Bupa restraint management programme. Restraint audits are included in the annual audit Schule. The most recent restraint audit during November 2020 achieved 100%.

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 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	Complaints reviewed all documented an investigation, follow-up and resolution of issues raised. Staff have been made aware of complaints through staff meetings and handover information. Not all complaints documented a closure letter to the complainant.	Five of six complaint records reviewed did not document that the complainant had received documented closure information.	Ensure that all complainants have a documented communication regarding the outcome of the complaint. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	The service has a variety of meetings to ensure that quality outcomes and quality initiatives are communicated to staff. Meetings have been consistently held (a part of Covid limitations). Internal audits, complaints, and incident forms had action plans completed as needed, all of which documented follow-up. Meeting minutes did not consistently document that issues raised in meetings have been	Issues raised at meetings did not all document an action plan, a timeframe and person responsible. Not all issues raised were documented as followed up. Examples included: The need for new sensor mats and call bells (February 2019) and possible resident transfers (March 2019). On further investigation these issues had been	Ensure that meetings document follow-up where issues are raised and that the Bupa template for meetings are completed around timeframes and person responsible.

		followed up and closed.	rectified hence the low risk.	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	The staffing roster includes sufficient staff to provide safe and effective care, however not all roster gaps were able to be filled by competent staff due to unplanned and planned leave.	A review of the roster from 1 March to 31 March evidenced that there were three incidences a PM shift gap not filled, there were five PM shifts gaps covered by staff who were still orientating and overall the roster evidenced many extended shift, shift changes and swapped shifts. The service is in the process of recruiting for more staff.	Ensure that all roster gaps are filled by competent staff and that staff are recruited to ensure a stable roster. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. Intentional rounding occurs daily for those residents assessed as requiring this level of monitoring. However, not all intentional rounding charts had been fully completed.	Four intentional rounding charts were not fully documented as completed or completed in a timely manner.	Ensure all resident monitoring charts are fully completed in a timely manner and according to policy. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	All electrical equipment has been tested and tagged; however, some items are out of the prescribed date range for retesting. There is a planned and reactive maintenance programme, however some areas of the facility require attention.	(i) Six electrical items checked had expired test and tag labels. (ii) A number of building maintenance issues were present on the day of audit including (but not limited to): (a) holes in walls (outside rooms 6, 7, 11,12,16, 18, 20, 22, 21, 24, 25, 27), (b) broken wall covering allowing water ingress (shower 5), (c) broken tap (toilet 4), (d)	(i) Ensure all electrical equipment complies with current legislation. (ii) Ensure all identified building issues are addressed. 180 days

			rotten woodwork and damaged flooring (shower 4), (e) damaged door frame (rooms 11 & 16), (f) broken toilet lid and damaged door (toilet 3), (g) stained floor tiles in corridors, dining rooms and lounges, (h) Broken vinyl floor seams in the kitchen (opposite chiller 1 & outside vegetable store) and (i) Damaged wallpaper was apparent throughout the facility.	

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.