

Bupa Care Services NZ Limited - Fergusson Rest Home & Hospital

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Fergusson Rest Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 16 March 2021 End date: 17 March 2021
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	110

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
A number of shortfalls that require specific action to address	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	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

Fergusson Rest Home & Hospital provides rest home, hospital and secure dementia levels of care for up to 112 residents. On the day of the audit there were 110 residents.

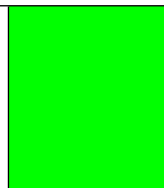
This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and general practitioner.

The general manager is a registered nurse. She has been in her role since September 2020. The general manager is appropriately qualified and experienced and is supported by a team of experienced staff. Feedback from residents and families was very positive about the care and services provided.

Nine of ten shortfalls identified as part of the previous audit have been addressed. These were around: meeting minutes, corrective actions, agency staff induction, staff training, timeframes for assessment and care plans, progress notes, care plan interventions, implementation of care, and self-medication management. There continues to be an improvement required around water stored for civil defence.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

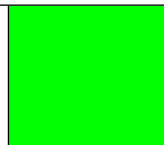


Standards applicable to this service fully attained.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



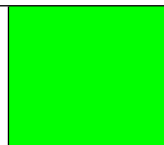
Standards applicable to this service fully attained.

Services are planned and coordinated and are appropriate to the needs of the residents. Quality and risk management processes are established. Business goals are documented for the service. The risk management programme includes a risk management plan, incident and accident reporting, and health and safety processes. Quality systems include regular monitoring of quality and risk data and an internal auditing programme.

Human resources are managed in accordance with good employment practice. An orientation programme and a regular staff education and training programme are in place. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

Registered nurses' complete initial assessments including interRAI assessments, care plans and evaluations within the required timeframes. Care plans are integrated and include the involvement of allied health professionals. Residents and relatives interviewed confirmed they were involved in the care planning and review process.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting and includes outings, entertainers and community interactions.

Medicines are stored and managed appropriately, in line with legislation and guidelines. Registered nurses and senior caregivers administering medications have completed annual competencies. The general practitioners review the medication charts at least three-monthly.

Meals are prepared and cooked on site under the direction of a Food Service Leader. The menus are provided by the national Bupa office. The menu is varied and provides meal options. Individual and special dietary needs are catered for. Nutritious snacks are available 24-hours a day. Residents interviewed were very complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The building holds a current warrant of fitness. External areas are safe and well maintained. Systems and supplies are in place for essential, emergency and security services.

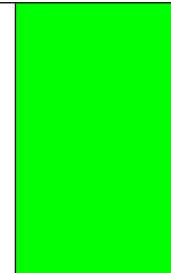
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. Eight residents were using a restraint and four residents were using an enabler at the time of the audit.

Infection prevention and control

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



Standards applicable to this service fully attained.

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.

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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	17	0	0	1	0	0
Criteria	0	46	0	0	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and families during the resident's entry to the service. Complaints forms are located at the entrance to the facility. The complaints process is linked to advocacy services.</p> <p>A record of complaints received is maintained by the general manager. Twelve complaints were lodged in 2020 and two for 2021 (year-to-date). Three complaints were reviewed for 2020 and two for 2021. Complaints have been managed in accordance with health and disability commissioner guidelines. All complaints reviewed were successfully dealt with and resolved. Staff are kept informed, as evidenced in the staff meeting minutes.</p> <p>Discussions with two rest home and two hospital level residents and families/whānau confirmed that they are provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. The resident survey results (December 2020) identified that residents and family were overall satisfied with the service (77%).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>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 (eight caregivers, two registered nurses, one cook, one activity person and the maintenance person) understood about open disclosure and providing appropriate information when required.</p> <p>Families interviewed; (two with a family member at hospital level and two with a family member on the secure</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>dementia unit) confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Eight accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. Staff and family are used in the first instance.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Fergusson Rest Home & Hospital provides rest home, hospital and secure dementia levels of care for up to 112 residents. On the day of the audit there were 110 residents. There are 10 dual-purpose beds. On the day of audit, there were 53 rest home residents and 41 hospital residents. There were 16 dementia care residents. Hospital residents included three younger persons under the younger person disabled contract and one respite, there were two residents funded through the long-term support – chronic health conditions (LTS-CHC) contract, one at rest home level and one hospital. There was also one rest home resident funded through an alternative contract. All other residents were under the age-related contract.</p> <p>A philosophy, mission, vision and values are in place. An annual business plan (2020) was implemented, with evidence of goals being reviewed. The general manager had documented the 2021 business plan, including annual goals of reducing slips, trips and falls.</p> <p>The general manager (RN) who has been in her role since September 2020 and has previous experience managing aged care services. She maintains a minimum of eight hours of professional development per year relating to the management of an aged care facility. The service is currently recruiting for a clinical manager. The general manager is supported by three registered nurse unit coordinators.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Fergusson rest home and hospital continues to implement the Bupa quality and risk programme.</p> <p>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. All new policies are communicated via the Bupa BMS monthly communication. The BMS is included as part of monthly meetings. Staff confirmed they are made aware of any new/reviewed policies.</p> <p>One to two monthly quality meeting minutes and monthly health and safety meetings (apart from Covid disruptions) sighted, evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs.</p> <p>The staff interviewed were aware of quality data results, trends and corrective actions. There are also two weekly clinical review meetings. These meetings document in-depth review of individual resident issues, complaints, new</p>

		<p>admissions, wounds, unintended weight loss, and wound care (as examples). The reporting of quality information, including incidents and accidents, restraint and infection control is an improvement from the previous audit.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. A summary of internal audit outcomes is provided to the quality meetings for discussion. Corrective actions are developed, implemented and signed off. This is an improvement from the previous audit.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident on the electronic system with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service's quality and risk management programme.</p> <p>Eight accident/incident forms were reviewed (witnessed falls and unwitnessed falls). Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurological observations are conducted for suspected head injuries and unwitnessed falls.</p> <p>The facility manager was aware of statutory responsibilities in regard to essential notification. Section 31 reports were evidenced for: two pressure injuries, one absconding resident, one missing resident and one power outage. Notification was also evidenced for a gastro outbreak (December 2020).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>FA</p>	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Seven staff files were randomly selected for review (four registered nurses including two-unit coordinators and three caregivers). 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.</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>The village general manager was able to discuss the orientation for agency nurses and the process of ensuring the agency staff provided safe care. This included working with the agency and having the same agency staff as much as possible. Three agency staff induction forms picked at random included a completed orientation. This is an improvement from the previous audit.</p> <p>The Bupa education and training programme is provided for staff. Education has been presented as training days, as well as repeated sessions. Toolbox talks (ad hoc and additional training sessions) have ensured a high attendance at training by staff. Competencies are completed specific to worker type and include (but are not limited to) medication, resident care and handwashing. A register of current practising certificates for health professionals is maintained. Five of thirteen RNs have completed their interRAI training. A first aid trained staff member is always available 24/7, including on outings.</p> <p>Eight permanent staff work in the dementia unit, five have achieved the level four-unit standards, and three are in progress. The three staff in progress have not worked at the unit for 18 months at the time of audit.</p> <p>The implementation of the Bupa training schedule to ensure that all staff attend at least eight hours training annually and ensuring timely appraisals for all staff is an improvement from the previous audit.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing levels meet contractual requirements. The general manager (RN) is on duty Monday to Friday and on-call after hours. Sufficient numbers of caregivers' support RNs. Interviews with the residents and relatives confirmed staffing overall was satisfactory and increased to manage resident acuity and occupancy. Staffing levels are as follows:</p> <p>Dementia unit (16 residents across 18 beds): morning shift - one RN/unit coordinator, two caregivers (one full and one short shift); afternoon shift – three caregivers (two full shift and one short shift (including one senior caregiver) and one caregiver on nights.</p> <p>Rest home (three hospital level and 50 rest home): morning shift - one RN/unit coordinator, four caregivers on full shift and two short shifts; afternoon shift – two caregivers on full afternoon and two until 9.30 pm (including a senior caregiver). One caregiver and one RN on nights.</p> <p>Hospital (41 hospital level residents); morning shift - one RN and a unit coordinator (RN), one RN afternoon and one for the night shift; four full morning shift caregivers and four short-shifts; afternoon six caregivers (two 3 pm - 11 pm, two 3 pm to 10 pm and two 4.30 pm to 8.30 pm). There are two caregivers and one RN at night.</p> <p>Activities staff are allocated to the rest home, hospital and dementia care unit.</p> <p>There are designated food services staff, cleaning and laundry staff seven days a week.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management. There was one rest home resident self-administering on the day of audit with documented competency on file. This is an improvement on the previous audit. There are three medication rooms on site, all have secured key-pad access. There are two medication trolleys used in the rest home and hospital communities. Medication fridges and treatment rooms had daily temperature checks recorded and were within normal ranges. All medications were securely and appropriately stored. Registered nurses or senior caregivers who have passed their competency, administer medications. Medication competencies are updated annually and include syringe drivers, sub cut fluids, blood sugars and oxygen/nebulisers. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There are no standing orders.</p> <p>The facility utilises an electronic medication management system. Fourteen medication charts were sampled (four dementia, six hospital and four rest home). All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of PRN medication administered were documented in the electronic prescription. Controlled drugs and registers align with guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen manager (who commenced December 2020) oversees the procurement of the food and management of the kitchen. The service is supported by one full time chef and two relieving cooks. All food services staff have attended food safety training. There are food service manuals and a range of policies and procedures in place to guide staff. There is a well-equipped clean kitchen, and all meals are cooked on site. The hospital and dementia food is delivered in scan boxes and rest home meals are served from a bain marie. There is a separate dining room in the dementia unit. On the day of audit, meals were observed to be hot and well presented. Audits are implemented to monitor performance. Kitchen chiller, fridge and freezer temperatures are monitored and documented daily; these were within safe limits. Temperature of food being delivered to the kitchen and prior to serving are also recorded. The service has a current food control plan which expires September 2021.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen by the registered nurse or unit coordinator. Special diets were noted on the kitchen noticeboard which is able to be viewed only by kitchen staff. A national summer/winter, four weekly rotating menu is in place. There was evidence that there are additional nutritious snacks available over 24 hours.</p> <p>The kitchen manager attends resident meetings, and surveys provide feedback on the meals and food service. Residents and relatives interviewed were happy with meals provided (they noted meals had improved since the current kitchen manager had commenced) and confirmed that alternative food choices were offered for dislikes.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Interventions were individualised and reflected the level of care and assistance required by caregivers. Previous findings were addressed. Wounds were documented separately with interventions listed also in the short or long-term care plans. Signs and symptoms for the adverse effect of warfarin use were well documented and the resident file of a resident who identified as Māori was reviewed showing a detailed cultural plan and on interview the resident was very happy with the care received.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses (RNs) and caregivers follow the care plan and report progress at each shift handover. If external allied health requests or referrals are required, the unit coordinators' initiate the referral (e.g., wound care specialist, dietitian, or mental health team). Relatives interviewed stated that the clinical care is good and that they are involved in the care planning. Interviews with unit coordinators, registered nurses and caregivers demonstrated understanding of the individualised needs of residents.</p> <p>Caregivers and RNs interviewed stated there is adequate equipment provided including continence and wound care supplies (sighted). Specialist wound, and continence advice is available by referral.</p> <p>There were 18 wounds on the day of the audit: two skin tears in the dementia community (one resident), seven skin tears in the rest home (four residents). The hospital community had; seven skin tears (six residents), and two unstageable pressure injuries (two residents).</p> <p>Wound assessment, wound plans and evaluation forms and photos were in place with a separate wound plan for each wound if a resident had more than one.</p> <p>The residents with pressure injuries had appropriate care documented and provided, including pressure relieving equipment and monitoring completed as instructed in the care plan. Access to specialist advice and support is available as needed. Care plans document allied health input.</p> <p>There was evidence of turning charts, monthly (or more frequent) weight and vital sign monitoring, food and fluid charts and behaviour charts in place. Unintentional weight loss has been discussed with the GP, and supplements were prescribed. Weight charts include percentage of weight gained or lost.</p> <p>Monitoring of residents, and wound care documentation are an improvement from the previous audit.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as</p>	<p>FA</p>	<p>There is an activities coordinator who commenced (along with another team member) late 2020. The activities coordinator has postgraduate training relevant to the position and is commencing diversional therapy training along with the other new team member. The four activities staff coordinate and implement an activities programme for each unit seven days a week. Two volunteers have recently commenced. On the day of audit, residents in all</p>

<p>part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>areas were observed being actively involved with a variety of activities. The monthly themed activities programme template is designed to cater for a range of cognitive, intellectual and physical needs. The monthly planner and weekly planner, which is displayed on noticeboards, is delivered to residents' rooms each week.</p> <p>Residents have an assessment and map of life completed over the first few weeks after admission, obtaining a complete history of past and present interests, career, family, etc. Attendance/participation in activities is recorded for each resident. Resident files reviewed identified that the individual socialising and activity plan is reviewed at least six-monthly as part of the care plan review.</p> <p>Activities in the dementia unit include (but are not limited to) newspaper reading, arts, crafts, music, weekly church services, pet therapy and board games. Van outings were in recess whilst a replacement driver was appointed. One-on-one activities include walks in the garden, hand massages and reminiscing.</p> <p>Rest home and hospital activities are similar to those offered in the dementia unit, but also include entertainment and physical games.</p> <p>Community links are maintained with visiting church groups and outings to places of interest and picnics will recommence when a van driver is appointed.</p> <p>The team receive suggestions and themes from Bupa national. On audit the theme was St Patricks Day, which residents appeared enthusiastic about.</p> <p>The service receives feedback and suggestions for the programme through surveys, three monthly relative and resident meetings in all units. Residents and relatives interviewed spoke positively about the activities programme and team members. The service encourages younger residents to be as involved in facility activities as they wish. Younger residents are encouraged to maintain their links to the community.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The files reviewed demonstrated that all interRAI assessments and care plans reviewed were evaluated at least six-monthly or when changes to care occurs. Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. All changes in health status are documented and followed up. The multidisciplinary review involves the RN, GP input, resident/family and unit coordinator. The files reviewed reflected evidence of relatives being notified of changes to care plans and reviews if not able to attend. In the files sampled care plans have been read and signed by the resident or EPOA/family. There is at least a three-monthly review by the medical practitioner. The residents and relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires on 19 November 2021. There is a 52-week planned maintenance programme in place. Electrical equipment has been tested and tagged. Hot water temperature is</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>monitored weekly in resident areas and at hot water cylinders.</p> <p>The corridors throughout the facility are wide, and handrails are available to promote safe mobility. Residents were observed moving freely around the areas with mobility aids where required. There are areas to wander inside and outside with secure garden areas off the Lavender (dementia) unit. Residents are encouraged to bring in their own possessions and are able to adorn their room as desired. There are quiet, low stimulus areas that provide privacy when required.</p> <p>Staff interviewed stated there is sufficient equipment available to staff in all areas that is calibrated.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation attendance documentation was sighted. Fire training and security situations are part of orientation of new staff and are ongoing as part of the annual training plan. There are adequate supplies in the event of a civil defence emergency including food, backup battery power and gas barbeque, but insufficient supplies of stored water (as per Civil defence guidelines) is a continued shortfall from the previous audit. Emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, toilets and showers and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The facility is secure after hours with security lighting and security patrols at night.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, trends, resources, and education needs within the facility.</p> <p>Individual infection reports are completed for all infections on the incident management programme (RiskMan). Infections are included on a monthly register and a monthly report is collated by the infection control coordinator with a corrective action plan. Infection control data and corrective actions are reported at the quality and staff meetings.</p> <p>The infection control programme is linked with the Bupa quality management programme. The results are subsequently included in the care home manager's report on quality indicators. Internal infection control audits and surveillance of infection control data assists the service in evaluating compliance with infection control practises and identifying infection control needs. There is close liaison with the resident's GP that advise and provide feedback/information to the service.</p> <p>One gastro outbreak during December 2020 was well managed and reported to the DHB and Public Health.</p>

		A Bupa companywide Covid strategy and pandemic plan was available to staff on site with education and associated resources relating to hand hygiene, PPE and donning/doffing procedures.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint is an agenda item at quality meetings. Documented systems are in place to ensure the use of restraint is actively minimised. There were eight hospital level residents using restraints and four residents using an enabler.</p> <p>Education and competencies on restraint minimisation are scheduled annually.</p> <p>Two resident files reviewed where a restraint was being used (one with bedrails and one with a lap belt) and one resident with an enabler (bedrails), all reflected an assessment and consent process had been completed with regular reviews. Residents using a restraint are monitored for safety.</p>

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 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.	PA Moderate	The service has at least three days of food stored, civil defence kits that are checked regularly, and has provided staff training. The water storage continues to not comply with DHB standard for water in the Hutt region	The service does not have sufficient water stored to comply with the civil defence guidelines of 20 litres per person per day for seven days.	Ensure the water stored for emergencies complies with the civil defence requirement. 90 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there 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.