

Blockhouse Bay Healthcare Limited - Blockhouse Bay Home

Introduction

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

The audit has been conducted by The DAA Group Limited, 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:	Blockhouse Bay Healthcare Limited
Premises audited:	Blockhouse Bay Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 May 2021 End date: 26 May 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:	59

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	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Blockhouse Bay provides rest home and hospital level care for up to 64 residents. The service is one of two privately owned and operated by the same provider. It is managed by a registered nurse (manager).

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, a visiting physiotherapist and a general practitioner (GP)

This audit identified one area of improvement relating to the provision of staff for activities and cleaning.

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.
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The complaints management system meets the requirements of the Code and is known by staff, residents and their families. Residents and family members interviewed reported that the manager immediately responds to and addresses any concerns they raise.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation.

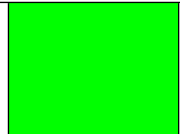
Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Care staff levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained using integrated electronic and hard copy files.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files

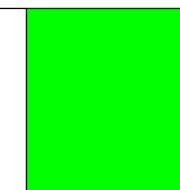
reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible to residents with shade and seating provided.

Waste and hazardous substances are safely managed. Staff use protective equipment and clothing. Soiled linen and equipment are safely stored. Laundry is undertaken onsite.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills.

Residents reported a timely staff response to call bells. Security is maintained.

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.

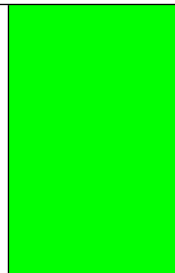


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Six restraints and no enablers were in use at the time of the audit. Use of enablers is voluntary for the safety of residents in response to individual requests. A comprehensive assessment, approval and monitoring process occurs. Regular evaluation and review of restraint use occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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 prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	49	0	0	1	0	0
Criteria	0	100	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Blockhouse Bay Home has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The manager provided examples of the involvement of Advocacy Services in relation to staff training and resident information sessions.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are encouraged to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment events in the community.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Even though there were visitors' restrictions recently due to the pandemic, residents and family members interviewed stated they felt comfortable about the way it was managed and were kept well informed</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed said they understood and wouldn't hesitate to raise concerns or complaints.</p> <p>The complaints register showed 11 written complaints and 7 verbal complaints had been received since the new Facility Manager (FM) took over in October 2020. Each complaint had been acknowledged in writing, investigations were carried out and where possible remedial actions were taken through to an agreed resolution within acceptable timeframes. The complainant signs that are satisfied with the outcomes. A family member and a resident who had both been involved in separate complaints said they felt their concerns were taken seriously by the FM who had responded in a timely and appropriate way. They commented that suitable actions had been taken The FM is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints investigations by the DHB or the Office of the Health and Disability Commissioner since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights</p>	<p>FA</p>	<p>Residents interviewed report being made aware of the Code and the Nationwide Health and Disability</p>

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>Advocacy Service (Advocacy Service) as part of the admission information provided and during discussions with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families of Blockhouse Bay Home confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by attending community activities and regular outings. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services through the district health board. Also, multilingual communication cards were developed to help communicating with residents.</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>The three year business plan outlines the purpose, values, scope, direction and goals of the organisation. Interviews and review of meeting minutes confirmed that the goals and objectives are reviewed for progress at three monthly management meetings. The FM also submits written monthly reports to the owners. A sample of these showed adequate information to monitor performance is reported including financial performance, emerging risks and issues.</p> <p>The service is managed by a registered nurse who holds relevant qualifications and has been in the role for seven months. This person has extensive experience in aged care as a clinical manager and acting facility manager. Responsibilities and accountabilities are defined in their job description and individual employment agreement. The manager confirmed knowledge of the sector, regulatory and</p>

		<p>reporting requirements and achieves at least eight hours a year of ongoing education through attendance at in service, and off-site meetings related to aged care management. Currently the FM is overseeing all clinical care.</p> <p>Blockhouse Bay has an Age Related Residential Care Contract (ARCC) with Auckland DHB for hospital medical and geriatric services, and rest home services including respite care.</p> <p>On the days of audit 60 of the 64 beds were occupied with 59 residents on site, as one rest home resident was in public hospital.</p> <p>There were 31 rest home residents, one of whom was under the age of 65 and funded under the Long Term Support-Chronic Health Care contract. One rest home resident was short stay/respite. There were 28 hospital level care residents. One was under 65 years of age and funded by Taikura Trust under a young person with disabilities contract (YPD).</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The FM has not had any planned or unexpected absences since taking up the role seven months ago. There is an arrangement that the FM role will be covered by the nurse manager from the other aged care home owned by the same company. This facility is within 20 minutes' drive from Blockhouse Bay. For unexpected short term absences (due to illness) the most senior registered nurse is appointed to carry out the managers required duties under delegated authority and the owner is also available to be on site.</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>	FA	<p>The service has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, regular resident, relative and staff satisfaction surveys, monitoring of outcomes, and clinical incidents including infections.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators. This information is reported and discussed at the management team meeting/quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. The FM writes a detailed corrective action plan each month which identifies all shortfalls and the actions required or those carried out to address these.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey showed that the residents/families and staff were satisfied with no concerns.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including</p>

		<p>reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The FM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There have been no staff injuries reported to Worksafe in this certification period.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, and actions carried out to prevent recurrence were implemented in a timely manner. All adverse event data is collated, analysed and reported to the management team and at staff meetings.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries. Three notifications of significant events have been made to the Ministry of Health and the DHB since the previous September 2020 audit. These include a change of facility manager in October 2020, a stage 3 Pressure Injury (resident admitted with this) and a missing resident in February 2021.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Of the 26 health care assistants (HCAs) six have completed level four, three have completed level three and six have completed level two. Two more HCAs are progressing their bachelor of nursing degrees. All newly employed HCAs are enrolled and supported to progress education by the activities coordinator who is an approved assessor for Careerforce, the education institute.</p>

		<p>Both cleaning staff have completed the Level two national certificate in cleaning.</p> <p>Records demonstrated that there were sufficient trained and competent registered nurses supporting the FM. Of the six registered nurse employed (including the nurse manager) four are interRAI trained and maintaining their competencies. Another RN is due to completing the training and one more is enrolled to begin.</p> <p>All staff engage in annual performance appraisals.</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>PA Moderate</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts care and clinical staff levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. One RN and eight HCAs are rostered on for morning and afternoon shifts (three in the upstairs wing, three downstairs and two in the rest home). There are three HCAs and one RN on site at night. The FM nurse works Monday to Friday and is available on call after hours.</p> <p>Additional staff need to be employed for activities and cleaning services.</p> <p>All the RNs are maintaining first aid certification so there is at least one staff member on duty with this.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from (NASC, GP etc.) for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whanau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Family members of the resident reported being kept well informed during the transfer of their relative.</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>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Regular medication audits are completed and are followed with appropriate corrective actions, when necessary. There was evidence of pharmacy involvement.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. The corrective action from previous audit was followed up and all medications sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within</p>

		<p>the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart. Standing orders are used, are current and comply with guidelines.</p> <p>There were no residents who self-administer medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors. No vaccines were stored onsite.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a kitchen team of two cooks and two kitchen assistants and is in line with recognised nutritional guidelines for older people. Blockhouse Bay Home has two menus in place and they follow summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Auckland Council effective from 25/05/2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident</p>

family/whānau is managed by the organisation, where appropriate.		and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	On admission, residents are assessed to develop an initial care plan. Within three weeks of admission, a comprehensive assessment is completed using nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening, depression scale and interRAI, as a means to identify any deficits and to inform long term care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents, except for residents who are needing care under respite care, long term support - chronic health condition have current interRAI assessments completed by trained interRAI assessor on site. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a	FA	The activities programme is provided by a trained diversional therapists holding the national Certificate in Diversional Therapy. Interview with diversional therapist (DT) revealed concerns about finding time for one to one session for resident who are not able to attend group activities. Also, the facility has multiple small lounges for activities and lack an area which accommodates bigger number

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>of residents. The DT is not able to oversee activities in all those areas at the same time. The number of activities hours are not sustainable with the increase in number of acuity residents, refer criterion 1.2.8.1.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six monthly care plan review.</p> <p>The monthly activities planner sighted matched the skills, likes, dislikes and interests identified in the assessments. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they are satisfied with the programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds and increased falls risk. When necessary, and for unresolved problems, long term care plans are updated to reflect the needs of residents. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>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.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a contracted GP service, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the eye clinic, mental health for older people and orthopaedic clinic. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous</p>

<p>Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>substances. Appropriate signage is displayed where necessary. The cleaner has completed safe chemical handling education. Material safety data sheets were made available where chemicals are stored at the time of audit. Staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There were sufficient stores of aprons, masks, gloves and gowns (PPE) readily availability in various locations. Staff were observed using these and interviews confirmed they understood donning and doffing of aprons, and appropriate use and disposal of PPE. .</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 24 June 2021) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the current residents' physical environment and facilities are fit for their purpose and maintained. Residents confirmed they are happy with the environment. The testing and tagging of electrical equipment occurred on 23 April 2021 and calibration of bio medical equipment and electric beds occurred on 01 February 2021.</p> <p>Visual inspection of the internal and external environment, documentation reviewed and interview with the maintenance person revealed that monthly hot water and weekly environmental temperature (medicines rooms) recordings were occurring. External suppliers visit monthly to test emergency and cleaning equipment and products.</p> <p>Efforts are made to ensure the environment is hazard free, safe for residents and supports their independence. Grounds contractors visit fortnightly but overlooked one side of the rest home building where garden debris was building up. This was being rectified by staff on the day of audit.</p> <p>A sanitiser has now been installed in one of the sluice rooms and is in use for hygienic cleaning of bedpans and urinals as required at the surveillance audit in August 2020.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility.</p> <p>Each bedroom has a hand basin and the majority have their own toilets. Two rest home rooms share a shower and a toilet. Five hospital rooms have a toilet and no shower, and one hospital room has no shower or toilet. All other hospital rooms have a shower and toilet. There are sufficient showers and toilets in each common area for shared use, for example, three in the older rest home wing which has 20 rooms and two on each floor in the newer building, for approximately 20 rooms upstairs and 20 downstairs. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms are single occupancy except for one room which is shared by a husband and wife as they requested. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is sufficient space inside and around the facility to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities, but currently the downstairs 'rest home' dining area is the main area that residents assemble for morning exercises, newspaper reading and crafts. An upstairs lounge and two other dining areas could be utilised for group and individual activities if there were more activities staff to facilitate this. Refer to criterion 1.2.8.1</p> <p>There are two shared dining and lounge areas downstairs and one upstairs which enables easy access for residents and staff. A number of residents prefer tray service for meals in their rooms. Residents can access their bedrooms for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site by the care staff designated to work in the rest home, although other care staff assist with this where needed. Two care staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. They had no concerns about being able to complete laundry tasks during their shifts, except on some days when attendance at meetings and training shortened their available time. No laundry services occur at night but the afternoon shift assist with folding and delivery of clean laundry. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. A commercial washing machine and dryer have been installed as required at the partial provisional audit in 2019</p> <p>The two designated cleaners have completed the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), confirmed in interviews and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>The effectiveness of cleaning and laundry processes are monitored through the internal audit programme and the visiting chemical supply company also checks the effectiveness of chemicals and provides support to staff about the safe use of these. Visual inspection of all areas in the home and negative feedback from some family members interviewed revealed a need for more in depth cleaning in some areas. For example, the high areas in the rest home corridors where cobwebs and dirt on light fittings were visible and not all bedrooms in the new building were being fully cleaned</p>

		<p>each day.</p> <p>There is a requirement to review the cleaner's workload now that resident numbers have increased and the additional 40 bedrooms are occupied—refer criterion 1.2.8.1</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The previous audit identified an area for improvement to ensure that an approved fire service evacuation plan is in place covering the new building and that staff have undertaken a fire drill in the new building. The corrective action is now addressed, and records were available to demonstrate this.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 31 July 2019. A trial evacuation takes place six-monthly with a copy sent to Fire and Emergency Services New Zealand (FENZ), the most recent being on 24 February 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the National Emergency Management Agency recommendations for the region.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. There are closed circuit cameras located in common areas of the hospital the exit doors and in the car park. These are monitored from the nurses' station and the owner/directors cell phone. Notices informing about the cameras are on display and information about the cameras is included in the written information provided to new residents and their families.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. All resident bedrooms and common areas have natural light and opening external windows. Heating is provided by underfloor heating in the older rest home building, including in residents' rooms and the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> <p>The new building has heat pumps in all residents' bedrooms and in the common areas. The upstairs</p>

comfortable temperature.		windows have security stays on them to prevent them from opening too wide.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.</p> <p>The clinical coordinator/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the FM and tabled at the staff meeting. The IPC committee includes the facility manager, IPC coordinator, Registered Nurses, health care assistants and representatives from food services and household management.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Due to the Covid-19 pandemic all visitors are requested to log their visit by entering their details on a paper log or by scanning a Ministry of Health bar code. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator who is supported by the current Facility Manager, has appropriate skills, knowledge and qualifications for the role, and has been in this role for two months. She has attended relevant study days, as verified in training records sighted. Additional support and information is accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. There were no infectious disease outbreaks reported in the facility since the last audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility.</p>

<p>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.</p>		<p>Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. Hand washing and donning doffing of personal protective equipment trainings have been completed as a part of recent pandemic preparedness</p> <p>Health education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.</p>
<p>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.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and others. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the Facility Manager. Data is benchmarked internally and compared against previous year's data. This comparison has provided assurance that infection rates are lower than last years.</p> <p>Covid-19 pandemic preparedness document is sighted, and staff interviewed were aware of this plan.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The RN restraint coordinator provides support and oversight for enabler and restraint management in the facility and</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, six residents were using bedrails as restraints. One of these residents also required a lap belt when sitting. There were no residents using enablers.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	<p>FA</p>	<p>The restraint approval group, made up of the FM, the GP and the RN restraint coordinator are responsible for assessment and approval and review of the use of restraints and all other care staff for safe implementation and monitoring of restraints when they are in place. The job description for the restraint coordinator has clear lines of accountability.</p> <p>Residents' files and interviews with the coordinator showed that each restraints had been approved by the GP and consented to by the residents enduring power of attorney or nominated family member following their involvement in the decision making process. Use of a restraint was clearly identified in each resident's plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN restraint coordinator undertakes the initial assessment with input from other RNs and the resident's family/whānau/EPOA. The /restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members for example, the use of sensor mats and low beds.</p> <p>When restraints are in use, frequent monitoring (hourly) occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed regularly. The sighted register contained sufficient information to provide an auditable record including an accurate and current list of</p>

		<p>the residents using a restraint.</p> <p>Staff attended training in the organisation's restraint policy and procedures and related topics, such as positively supporting people with challenging behaviours the week before this audit. Staff spoken to understand that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of three of the six residents' files who were using restraint showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, and at two monthly restraint evaluations. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator and FM have conducted an annual review of all restraint use in January 2021 which included information to meet all the requirements of this Standard. The report contained analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the GP, staff and families.</p> <p>Data reviewed, minutes and interviews with the FM and restraint coordinator confirmed that the use of restraint has reduced from 13 to 6 over the past four months.</p> <p>The FM provides monthly reports on restraint activities to the owners, RNs and staff at their meetings. Six-monthly internal audits are also carried out which informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated.</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)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA</p> <p>Moderate</p>	<p>There is only one diversional therapist employed 40 hours per week to provide activities for up to 64 residents. This person also assesses and moderates the CareerForce training programme for HCAs which takes up to two hours per week. The 2019 staffing plan for the addition of 40 hospital beds indicated there would be additional activities staff hours but this has not been implemented. One activities staff member cannot realistically meet the individual and group social and recreational needs of 60 residents.</p> <p>Two cleaners are now employed who share the 56 hours of cleaning time allocated each week. One cleaner is rostered to be on site seven days a week for eight hours a day. Taking into account the size of the facility, the number of bathrooms, toilets and resident bedrooms (now close to full occupancy) and other evidence, indicate that one person per day is insufficient . Although the common areas are cleaned daily, some bedrooms are only ‘spot cleaned’ each day, and given a full clean when needed. Staff interviews, visual inspections and feedback from families identified the need for an additional person to be allocated to cleaning and</p>	<p>There is insufficient activities hours to cater to the needs of residents for the variety of group work and for individual time for those with high needs who cannot participate in group work</p> <p>Feedback from residents, their families and visual</p>	<p>Ensure there are sufficient numbers of staff allocated for cleaning and activities to effectively complete tasks and meet the needs of residents.</p> <p>90 days</p>

		activities for sufficient hours to complete the work required. Refer to further evidence in 1.4.6 and 1.3.7.	observation confirms that cleaning is not being completed as required in all areas to meet standards of cleanliness.	
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.