

# Blockhouse Bay Healthcare Limited

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## 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 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:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 18 February 2015      End date: 18 February 2015

**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:** 28

# Executive summary of the audit

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## 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  |
|-----------|--|---|
| Yellow    | 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 |
| Red       | 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 Home provides rest home services for up to 43 residents. On the day of audit there were 28 residents receiving care. A registered nurse manages the facility. All the residents and family members interviewed spoke very positively about the staff, personalised care and the standard of services received.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the provider's contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed the two shortfalls from the previous certification audit around replacing the kitchen bench and installing privacy locks on ensuites and undertaking repairs in a bathroom.

This audit identified that improvements are required in three areas relating to maintaining the complaints register, essential notifications and medication documentation.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of low risk. |
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Staff communicate with residents and family/whanau members following any incident in a manner that is reflective of open and honest communication.

Staff, residents and family members are aware of the complaints process. Complaints are being investigated and addressed. The complaints register was not complete and this requires improvement.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | 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 organisation's vision, values and mission are documented in the business and strategic plan. There is a documented quality and risk plan. These have been developed by an external consultant and localised to reflect the needs of Blockhouse Bay Home.

The quality programme includes complaints management, incident reporting and policy and procedure review. Applicable policies are current and available to staff. The administrator is responsible for document control processes. There is a risk management plan and hazards are being identified and reviewed. Internal audits and surveys are conducted. Where improvements are required in processes this occurs in a planned manner. Essential notifications are not occurring in a timely manner and this requires improvement. Regular resident and staff meetings occur.

Staff recruitment includes the applicant completing a job application. Reference and police checks are conducted. Annual performance appraisals have been completed for applicable staff. An orientation programme is in place for new employees and records of this are maintained. Staff have access to relevant ongoing education and are working towards an industry approved qualification.

The staffing and skill mix policy requirements are implemented to ensure the residents' care needs are met. The requirements align with the provider's contract with Auckland DHB. A staff member with a current first aid certificate is rostered on each duty. The manager is a registered nurse who works fulltime hours and is available by telephone when not on site. The owner/director is also available to the management team.

## Continuum of service delivery

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

All residents' files sighted provided evidence that needs, goals and outcomes are identified and reviewed on a regular basis with the resident, and where appropriate their family/whanau. Resident and family/whanau members interviewed reported that they are satisfied with the services provided.

The assessment, provision of care and review of care is provided within timeframes to safely meet the needs of the residents. Services are coordinated in a manner that promotes a team approach and continuity of care. Care planning is based on assessment findings.

Planned activities provided reflect residents' strengths, interests and level of ability.

Medicine management procedures undertaken by staff during medication rounds reflect safe medicine management practices. However medication management documentation is an area which requires improvement.

The menu has been reviewed as meeting nutritional guidelines by a registered dietitian. Residents' special dietary requirements and cultural needs are met. Interviews with residents verified a high level of satisfaction with meals. The one area identified for improvement in the previous audit around kitchen facilities has been addressed by the service.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |
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The building has a current building warrant of fitness. Residents' rooms have been progressively renovated. Landscaping has also occurred. Privacy locks have been fitted to the ensuite bathrooms and required repairs completed. This now meets the standard. Fixtures and fittings were fit for purpose.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |
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Policies and procedures are in place should staff require them to implement safe restraint minimisation procedures. They identify that enablers are voluntary and the least restrictive option to allow residents to maintain independence, comfort and safety. Currently there are no enablers or restraints in use and the service strives to maintain a restraint free environment.

## Infection prevention and control

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

Surveillance for residents' infections is occurring and is appropriate to the service setting. Episodes of infection are being communicated to the resident, family, general practitioner and staff in a timely manner and treatment provided. The number and type of infections are being discussed at the monthly staff meetings and compared with other residential aged care facilities.

## 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 14                  | 0  | 1                                    | 2  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 36                  | 0  | 1                                    | 2  | 0                                      | 0  |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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>     | PA Low            | <p>The complaints policy detailed the residents or family member's right to make a complaint. The process for reporting, investigating, documenting and following up the complaint was documented and the timeframes aligned with the requirements of the Code.</p> <p>The manager advised there have been no complaints received from the Health and Disability Commissioner (HDC), District Health Board (DHB) or Ministry of Health (MOH) since the last audit. A complaints register was being maintained, however does not include details of all complaints received.</p> <p>All the residents and family members interviewed confirmed being aware of the complaints process and having no complaints.</p> <p>The staff interviewed were able to detail their responsibilities in the event a resident made a complaint.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p> | FA                | <p>Resident and family/whanau interviews confirmed they are communicated with in an open and honest manner. Staff interviewed confirm they understand and implement policy to ensure communication reflects the principles of open disclosure. Residents and their family/whanau members are consulted, included</p>  |

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| <p>effective communication.</p>   |           | <p>and involved in care provision changes and reviews undertaken by nursing staff. Communication with family/whanau documentation was sighted in all residents' files reviewed. Incident/accident forms identify family/whanau are informed when an incident occurs.</p> <p>The manager and owner confirm the service would use interpreters if and when required. Staff confirm they would be guided by policy to implement this process.</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>Blockhouse Bay Home has a 2013 to 2015 business and strategic plan. This was developed by an external consultant and has been personalised to Blockhouse Bay Home. The mission, values and scope of the service are detailed and relates to the provision of rest home level care. The owners purchased this rest home in August 2012. The owner reports progress in achieving the business and strategic plan was monitored via the service review meeting and resident/staff feedback.</p> <p>The manager is a registered nurse with a current annual practising certificate. The manager works full time on site and is responsible for ensuring the day to day care needs of the residents are met. The manager is experienced in the aged care sector and has worked in this home since September 2012. The manager reports to the owners/directors who also own two other aged care facilities in Auckland. The owner confirms being kept well informed by the manager and administrator.</p> <p>The manager attended regular education and has completed more than eight hours of education related to managing an aged care facility in the last 12 months (as required by the providers' contract with Auckland District Health Board). All residents and family members interviewed spoke very highly of the management team as well as the care they are receiving. Those residents who have lived in Blockhouse Bay Home prior to the current owner purchasing the facility commented positively on the physical improvements which have been undertaken to the building and grounds.</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>There is a documented quality and risk plan sighted. This has been developed by an external consultant and personalised for Blockhouse Bay Home.</p> <p>Policies and procedures are available to guide staff practice. The policies have been developed and reviewed by an external consultant and then personalised to reflect the needs of Blockhouse Bay Home. Three copies of the policies are</p>  |

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|  | <p>available for staff with an electronic copy available only to the management team. Document control processes is the administrators' responsibility.</p> <p>A review of the quality and risk programme is undertaken via the service review meeting. Template forms assist the management team and owner in ensuring all relevant issues are regularly included. This includes details of occupancy, hazards, referrals, the results of audits, infection data and the number and type of reported incidents. There is some variation between the incident data reported in the meeting minutes and that noted on the incident register. The administrator advised this was a data entry error.</p> <p>Internal audits have been undertaken and are conducted using template forms. The six audits sampled related to kitchen/food hygiene, laundry services, resident care plan audit, single use items, informed consent and concerns/complaints. The audit reports confirm there is very good compliance by staff in meeting the requirements of the policy and audit criteria. Where improvements were required these improvements have been implemented.</p> <p>A resident satisfaction survey was conducted in September 2014. The results were very positive. A separate food satisfaction survey identified the residents were very satisfied with the food services. Resident compliments were recorded and communicated to staff.</p> <p>Resident meetings have been regularly held. Family members are able to attend. The most recent was in January 2015 and there is good attendance. Minutes sighted reflected a high level of satisfaction with the services provided including the activities programme and food services.</p> <p>Staff meetings are held monthly. The minutes of the last three meetings were reviewed and included information on audit results, incidents/accidents and changing individual resident's needs, residents who have developed an infection, facility routine, uniform, policy/processes, staff training/education and other issues relevant to the service.</p> <p>Staff are required to report any hazards. A reporting form is sighted in the nursing station and staff document hazards and maintenance concerns. Where hazards/maintenance concerns have been identified these have been eliminated or minimised. A hazard register was available that detailed a range of hazards related to the facility/environment as well as resident care. The mitigation strategies have been detailed. The hazard register is dated January 2015 and utilises pictures to help communicate the key messages.</p> |
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|   |                        | A risk management plan is in place. Organisation risks are categorised and documented and mitigation strategies noted. The owner reported the risks as detailed are unchanged.   |
| <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>PA<br/>Moderate</p> | <p>There is an incident and accident reporting policy which is implemented by staff. Applicable events are being reported in a timely manner and also disclosed to the resident and or designated next of kin. This is verified by resident and family members interviewed who confirmed they are always kept informed.</p> <p>Short term care plans were used to provide guidance for the caregivers appropriately. The sample of incident reports reviewed at random demonstrated prompt reporting, investigation and follow-up was occurring. Reported events were discussed at the regular staff meetings and service review meetings as confirmed by staff interviewed and verified in the meeting minutes sighted.</p> <p>Blockhouse Bay Home also benchmarked incident related data with other residential aged care facilities and this data was sighted.</p> <p>While the manager was able to detail some of the events that require notification, it is observed that two events have not been reported as required.</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>   | <p>FA</p>              | <p>The policy on human resources management was sighted. The copy of the annual practising certificate (APC) for the general practitioner (GP), registered nurse (RN) and physiotherapist on file had expired. A copy of the current documents was obtained and sighted during audit. The administrator has since developed a process to monitor when practising certificates are next due. The copy of the APCs on file for the two pharmacists were current.</p> <p>The recruitment/employment process included staff completing an application form, police vetting, and reference checks. Staff have a signed employment agreement and confidentiality/privacy agreement on file. Performance appraisals are conducted annually and these were sighted in relevant staff files. The manager maintains a register of when these and the medication competency assessments are due.</p> <p>Records evidencing completion of the orientation programme were present for staff employed under the current owner. Longstanding employees that worked for the previous owner had a signed current employment contract on file. Staff interviewed</p> |

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|  |                | <p>report the orientation included at least three shifts being buddied with a senior staff member. The orientation included the facility, policy/processes, facility routine, staff tasks, and the individual resident care needs.</p> <p>Individual records of education are maintained for each staff member and copies of certificates are present in the five staff files reviewed. In-service education and attendance records were sighted showing staff had access to regular ongoing education relevant to their roles and the service. Staff are working towards completing an industry approved qualification. There was a high level of attendance from staff at the in-service education sessions.</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>    | FA             | <p>A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with ADHB.</p> <p>At least one staff member on each shift has a current first aid certificate and these were sighted. The current roster was reviewed and demonstrated that there are three caregivers on morning shift, two caregivers on an afternoon shift and one staff member on night shift. There is an additional staff member on site overnight that 'sleeps over'. This staff member provides support as and if required. Additional hours are rostered for the activities programme, kitchen and cleaning services.</p> <p>The manager is on site Monday to Friday and is available on call and for support after hours and on weekends. All caregivers interviewed report that there is adequate staff available and that they are able to get through their work. The staff confirm the manager is available out of hours if required.</p> <p>Residents and family members interviewed report that there is enough staff on duty to meet their needs.</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> | PA<br>Moderate | <p>With the exception of liquids and non-regular medicines, medicines are supplied by the pharmacy in a pre-packed administration system. Non-packaged medicines are individually supplied for each resident. The service has a system in place for the checking of medicines when they are delivered to the facility from the pharmacy. The GP conducts medicine reconciliation on admission to the service, three monthly reviews and when the resident has any changes made by other specialists. Some residents reported that the GP does not always explain the changes made to their medications but that the RN gives them a full explanation.</p>  |

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|   |           | <p>Safe medicine administration was observed at the time of audit and all safe practice protocols were undertaken. The medicines, including controlled drugs, are securely stored. The temperature of the medicine fridge is not monitored. The controlled drugs are signed out by two staff when administered and a weekly stock count recorded in the controlled drug register.</p> <p>All the medicine charts sighted are generated from the three monthly GP prescriptions which is signed at the bottom of the page for all listed medicines. The information sighted on each prescription matches what is on the pharmacy generated medicine chart. The GP prescriptions and pharmacy generated medicine charts are legible, record the name, dose, route, strength and times for administration. However, the medicine charts do not have a separate area for short course and 'as required' pro-re-nata (PRN) medicines.</p> <p>There were nine separate forms in the medicine charts (with residents' names) which explained the PRN medicine actions and what they were to be used for, but this did not consistently match what was on the prescription. The clinical staff interviewed stated they understood the medicine charts and only followed the GP instructions. (Only residents with PRN medicines have this third separate computer generated form).</p> <p>The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification is recorded for all staff who administer medicines. Medication competencies were sighted for all staff that assist with medicine management.</p> <p>The service's policies, procedures and self-administration guidelines are implemented for the one resident who self-administers their inhalers. When interviewed the resident was able to fully describe what their medication was for and verified staff observe that they are able to administer them correctly.</p> <p>Family/whanau interviewed and documentation in residents' files confirmed changes to medications are notified to family/whanau by the manager when this occurs.</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>One area identified for improvement in the previous audit related to the kitchen bench top has been addressed. There is a new bench top in place.</p> <p>The service uses a menu which has been reviewed and approved by a registered dietitian as suitable for the older person living in long term care. (This is undertaken at organisational level).</p>  |

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|   |    | <p>Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The cook confirmed during interview that all resident needs can be met. Kitchen services receive a copy of the residents' nutritional profiles, with the residents' preference and special diets recorded which are updated as required. The residents and family/whanau interviewed report that the meals are very good and that they always have fluids available. Likes and dislikes are well managed.</p> <p>All aspects of food procurement, production, preparation, delivery and disposal complies with current legislation and guidelines. Faulty equipment is removed and replaced when required. Fridge and freezer recordings are undertaken daily and temperature recordings sighted meet requirements.</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>  | FA | <p>The file reviews undertaken contained documentation that guides staff actions. The information is up to date and clearly describes the interventions to meet residents' needs. Residents and family/whanau interviewed confirm the services they receive meets their needs. The care plans reviewed are individualised and personalised to meet the assessed needs of the resident. Service delivery is resident focused.</p>   |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>Activities are planned in a manner which is reflective of residents' strengths and interests. This is confirmed during resident interviews. Information from residents' social assessments and physiotherapy assessments has been used to guide the activities offered. The activities offered cover a broad range of items and are aimed to include meaningful activities for all residents. Attendance records sighted identify all but one resident, who confirmed during interview they do not wish to join any activities, participate in the activities offered to some degree. Planning identifies that the activities are modified according to the capability and cognitive abilities of the resident. The activities programme covers physical, social, recreational and emotional needs of the residents. Residents are transported by the service to attend off site social activities and to undertake personal tasks such as going to the bank or meeting friends for coffee.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>   | FA | <p>The evaluations of care are conducted six monthly and indicate the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes. This occurs more frequently if there is a change</p>   |

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| <p>comprehensive and timely manner.</p>   |           | <p>made to a resident's care requirements. Changes are clearly identified in progress notes, on the daily handover sheet and in the clinical diary. Short term care plans are in place for temporary changes to health status, such as an infection or wound care.</p> <p>The residents and family/whanau interviewed report a high degree of satisfaction with the care provided at the service.</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>The facility has a current building warrant of fitness and this was sighted. Since the last audit the owner has been progressively renovating residents' bedrooms (painting and replacing the net curtains). The minutes of the service review meeting in August 2014 identified that 11 rooms had been completed at that time with further rooms completed since then. Landscaping has been undertaken at the front of the rest home to provide additional garden area and furniture for residents and their family to utilise.</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>At the last audit and improvement was required in relation to repairs of a shower and installing privacy locks on the ensuite toilet doors. These have been addressed. Latches have been installed on the bathroom doors and these were sighted during audit.</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>Surveillance is being conducted of residents who develop an infection. The surveillance programme is appropriate to the service setting. The results are being communicated to the manager, general practitioner and staff. The infection rates are also benchmarked with other residential aged care facilities and this data was sighted. The infection rate is generally low.</p> <p>Residents suspected of having an infection are being provided with timely care as verified by another member of the audit team. Staff interviewed are able to describe the signs and symptoms a resident may have that could be considered a sign or symptom of infection and require reporting to the manager. The manager advises there have been no infection outbreaks since the last audit.</p> <p>Residents and family members interviewed confirmed they are kept fully informed about all changes in the resident's health and changes in treatment and care.</p> |

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| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>The service policy and procedures identify that the use of enablers shall be voluntary and the least restrictive option to assist residents to maintain independences in a safe and comfortable manner. As identified in the restraint register, staff meeting minutes and during staff interviews the environment remains restraint and enabler free. Staff confirm their understanding of following the policy and procedures should restraint be required.</p> |
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## 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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | PA Low            | <p>A family member interviewed stated a complaint had been made. This had been investigated and responded to in a timely manner and resolved to the complainant’s satisfaction. This complaint and another complaint that is noted in recent staff meeting minutes has not been documented in the complaints register.</p> <p>The manager advises there are very few complaints received. Those complaints noted in the register have been investigated and responded to on the date the complaint was received.</p> | The complaints register does not include details of all complaints. | <p>Ensure the complaints register is updated to include all complaints, dates and actions undertaken</p> <p>180 days</p> |
| <p>Criterion 1.2.4.2</p> <p>The service provider</p>   | PA Moderate       | The manager discussed essential reporting requirements and provided some examples of the type of events to   | Two events have not been notified as an essential                   | Ensure all applicable events are reported to the appropriate authority in a  |

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|---|------------------------|--|---|--|
| <p>understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>  |                        | <p>be reported. Two events discussed at audit have not been reported as required. This included an allegation of assault that was reported to the police and a small fire in the facility.</p>   | <p>notification.</p>  | <p>timely manner.<br/><br/>90 days</p>   |
| <p>Criterion 1.3.12.1<br/>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | <p>PA<br/>Moderate</p> | <p>Clinical staff interviewed reported a clear and safe understanding of the procedures required to ensure safe medicine management as described in policy. This was verified during an observed medication round. Medicines are reviewed, stored and disposed of in a manner which complies with legislation, protocols and guidelines.</p> <p>Insulin is kept in a separate medication fridge in the kitchen but temperature monitoring does not occur.</p> <p>There are three monthly medication computer generated prescriptions which the GP signs at the bottom for all listed medicines and then the pharmacy generates a medicine chart and signing sheets that correspond with what the GP has requested. The pharmacy generated medicine sheet has all medications listed in one area and PRN medications are shown in the same section as regular medicines. Not all medication instructions related to PRN medications are consistent as the instructions on the resident medicine chart sometimes differs to what is stated on a separate instruction document related to the reason PRN medication is to be given.</p> | <p>The medication fridge which contains insulin does not have temperature monitoring occurring and is in very poor condition.</p> <p>Pro re nata (PRN) medications are identified on each resident's medication chart under the same section as regular medications. Nine residents have a separate PRN instruction chart with information which does not consistently match the information on the medication chart.</p> <p>The general practitioner signs the bottom of each three monthly prescription and not for each medication. This does not constitute safe or current accepted good practice, nor is it in accordance with the MoH document 'Medicine Care Guides for Residential Aged Care' (page 14).</p> | <p>Ensure that medication management systems are implemented to reflect safe and appropriate prescribing that reflects current legislation, protocols and guidelines and current best practice.</p> <p>90 days</p> |

## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.