

Henrikwest Management Limited - The Beachfront Rest 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: Henrikwest Management Limited

Premises audited: The Beachfront Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 6 August 2019 End date: 7 August 2019

Proposed changes to current services (if any): On the 5 August 2019 the service was authorised by the MoH to accept hospital level residents (39 dual purpose beds and 16 rest home beds); total beds increased to 55 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 36

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
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

The Beachfront Rest Home provides rest home and hospital level care (from the 5 August 2019) for up to 55 residents. The service is operated by Henrikwest Management Limited and is managed by a general manager who is the temporary facility manager for this site. The group consists of three facilities. A clinical manager currently works three days a week at this facility and two days at another facility.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the Waitemata District Health Board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, managers, staff and a general practitioner.

The audit has resulted in no areas identified as requiring improvement; however, three improvements identified in the last partial provisional audit remain open in relation to the addition of dual-purpose beds including staffing, activities resources and a lift to be replaced.

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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Residents and their families are provided with adequate information about the Health and Disability Commissioner's Code of Health and Disability Consumers' Rights (the Code) and these are respected. Services are provided that support privacy, dignity, independence and individuality.

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 to give consent.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. There are no barriers identified for Maori being admitted to this service. There was no evidence of abuse, neglect and/or discrimination. Staff receive appropriate training.

The service has linkages with a range of specialist healthcare providers to support best practice and meet residents' 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 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. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and is not accessible to unauthorised people.

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.		Some standards applicable to this service partially attained and of low risk.
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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 registered nurse and the general practitioner assess residents' needs on admission. The care plans are individualised based on a comprehensive range of information and accommodate any new problems that might arise. Records 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 diets and events being catered for. Food is safely managed. The service has a food control plan displayed. Residents verified satisfaction with the food service.

Safe and appropriate environment

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

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

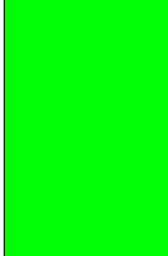
Restraint minimisation and safe practice

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Six enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. The restraint committee meet six monthly to review the use of enablers. No restraints were in use. Policy identifies that comprehensive assessment,

approval and monitoring process meet restraint standard requirements. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection prevention and control programme is led by an experienced and trained infection control coordinator who 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 surveillance is undertaken monthly and results are reported to management. 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	42	0	3	0	0	0
Criteria	0	90	0	3	0	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	The Beachfront Rest 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 residents to be independent and maintaining dignity and privacy at all times. Training on the Code is included as part of the orientation process for all new staff employed and is in ongoing education and training that was verified in the training records reviewed.
<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	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent was defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.

<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.</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 assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family members and friends. Volunteers from the community visit on a regular basis. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Residents and family have access to the main lounge and have access to the outside garden and seating areas.</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. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaints forms are available at the entrance to the facility.</p> <p>The complaints register reviewed showed that 17 verbal complaints had been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within the timeframes. All complaints are documented by staff and action plans showed any required follow up and improvements have been made where possible. The clinical nurse manager and general manager are 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 received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the information pack provided on admission and discussion with the registered nurses. The Code is clearly displayed in all service areas and pamphlets on how to make a complaint, the Code and advocacy services were accessible at reception.</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 interviewed confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have their own room.</p> <p>Residents are encouraged to maintain their independence by community activities, and participation in ay clubs or services in the community. Care plans included documentation related to the resident’s abilities and strategies to maximise independence.</p> <p>Residents’ records confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified and documented into their individual care plans.</p> <p>Staff interviewed understood the service’s policy on abuse and neglect which included what to do should there be any signs. Education on abuse and neglect was confirmed to occur at 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 whānau. The senior registered nurse interviewed reported that there were no residents who identified as Maori at the time of audit. There were no staff who identified as Maori. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. The Maori cultural policy states that there is a specific current Māori health plan, and all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and would then be integrated into a resident’s long-term care plans, when needed. Guidance on tikanga best practice is available and is supported by the Maori health advisors at Waitemata District Health Board (WDHB) if and when required.</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, for example, spiritual beliefs. The resident satisfaction survey confirmed that individual needs are being met. Family confirmed that ethnic, cultural values and beliefs were effectively met.</p>
<p>Standard 1.1.7: Discrimination</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>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 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, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, 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. Policies and procedures were consistently reviewed and the facility manager approves all documents prior to implementation.</p> <p>Other examples of good practice observed during the audit included day to day discussions between staff, residents and relatives. One resident interviewed stated that staff when providing support with daily activities of living, ensured that her privacy was maintained at all times. Staff were observed maintaining privacy.</p>
<p>Standard 1.1.9: Communication 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 WDHB and the contact number was available. Staff interviewed stated that interpreter services were however rarely required due to all residents able to speak English and staff being able to provide interpretation as and when needed. The senior registered nurse interviewed stated that there was good communication with families/whanau and families interviewed confirmed this. The GP interviewed also confirmed that communication was not compromised at any time with the nursing staff and others.</p> <p>There were residents who had significant sensory impairments which were reflected on the long term care plans reviewed. The care plans reviewed showed interventions and equipment was provided to promote ongoing independence, communication and support. Staff interviewed knew the residents well.</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 strategic, quality and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly and quarterly reports to the senior management group which includes the owner/director, showed adequate information to monitor performance is reported including quality data results, staffing, complaints, quality improvements made, emerging risks and issues.</p> <p>The service is managed by the general manager who is also undertaking the role of facility manager on a temporary basis until this role is filled and the clinical nurse manager. Both staff hold relevant qualifications. The general manager has been in the role for over five years and the clinical nurse manager, who works across two sites owned by the same owner/director, works two rostered days a week at The Beachfront Rest Home. They have been in the role for 18 months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Both the general manager and clinical nurse manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through regular ongoing clinical and management education related to their roles. This was confirmed in education documentation sighted. There is a senior registered nurse who works 40 hours per week at the facility who oversees the day to day clinical management of care.</p> <p>The service holds contracts with Waitemata District Health Board for rest home level care. (The service had Ministry of Health approval to offer hospital level care services the day before the audit). There were 34 rest home level care residents at the time of audit. Thirty-two residents were receiving services under the Age Related Residential Care contract, and two residents were receiving services under the Long Term Support-Chronic Health Care Community Residential Care contract (both of these residents were under the age of 65 years) at the time of audit.</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>	<p>FA</p>	<p>When the general manager/facility manager is absent, the business manager and assistant manager carry out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the senior registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and accidents, complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls, wound care, skin tears, challenging behaviour and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly management team meetings and staff meetings. A copy of all quality data and analysis reports are available to staff in a folder in the nurses' office. A recent improvement relates to the forming of the 'Viper group'. This is an electronic communication system which is completed daily to alert the general manager, clinical nurse manager, assistant manager, office manager, regional manager, owner/director, senior registered nurse and on call registered nurse of any concerns that arise so they are informed on a real-time basis. A detailed weekly report is also shared with this group to ensure any trends are identified early. This improvement is yet to be evaluated.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities, being members of specific groups such as restraint/infection control/health and safety and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (June 2019) showed that 100% satisfaction was gained with all services. One comment was made related to a missing piece of laundry and this was resolved by laundry staff. The positive comments related to the renovation of the facility lounge and dining areas, the type and variety of activities and the ease of access to the general manager and senior registered nurse are identified in the analysis. The general manager/facility manager stated that any concerns raised by residents or family members are followed up using the corrective action process.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed and kept up to date by an off-site provider and they are based on best practice and were current. The service personalises all policies. 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 general manager/facility manager 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. The service has a health and safety group who actively maintain and review all known and newly identified risks.</p>
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<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of accident/incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to management, clinical nurse manager, staff and families as appropriate. They are also included in the weekly quality review report sent to the members of the Viper group.</p> <p>The general manager/facility manager and the clinical nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health since the previous audit. There have been no police investigations, coroner's inquests, issues based audits and any other notifications, such as infection outbreaks, during this time.</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>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. The service is actively recruiting registered nurses prior to commencing hospital level care services.</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. Newly employed staff have a two weekly informal meeting with the general manager/facility manager for a three month period so that the service can assist the staff member with any areas they wish to receive further development. This was confirmed during staff interviews. Staff appraisals are undertaken annually and this process is monitored electronically by the senior registered nurse and the assistant manager.</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. A staff member from a sister facility is the internal assessor for the programme. Staff training and education is well documented and occurs both on-site and off-site. On-site education includes guest speakers such as the gerontology nurse specialist from Waitemata DHB and staff attend training days at the hospice for palliative care and specific age-related training via Waitemata DHB community training events. There are two trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments and one registered nurse who is part way through her interRAI training. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals related to interRAI.</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 Low</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 general manager/facility manager and owner/director are aware that the service is not able to admit hospital level care residents until they are able to provide 24 hour, seven day a week registered nurse cover. Observations of six weeks of staff rosters identifies that the facility adjusts staffing levels to meet the changing needs of residents. Staff are replaced in any unplanned absence. 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. Staffing levels meet the interRAI acuity level report findings. At least one staff member on duty across all shifts has a current first aid certificate.</p> <p>The general manager/facility manager, accounts manager, assistant manager and senior registered nurse work Monday to Friday for eight hours per day. The clinical nurse manager works two days a week and is on call. There are dedicated kitchen, cleaning and laundry staff seven days a week. Activities staff cover six days per week.</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 including the residents' national health index numbers are completed in the residents' records sampled for review. Clinical notes were current and integrated with GP and allied health provider records. 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 when required. Residents' records 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 the NASC and GP 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. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service</p>

		charges comply with contractual requirements. Residents' agreements were provided and all were signed and dated in a timely manner and stored appropriately and confidentiality was respected.
<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>	FA	<p>Exit, discharge or transfer is managed in a planned and coordinated manner with an escort as appropriate. The service uses the WDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between services, the resident and the family/whanau and GP. A transfer letter is always documented if referred by the GP or a transfer form if an acute admission. All referrals are documented in the progress records. The family/enduring power of attorney (EPOA) are kept well informed by the RN at the time. The 'SBAR' tool (a structured communication tool) is used when transferring residents to the WDHB.</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>	FA	<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 hard copy records was observed on the day of audit. The staff member 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. Competencies are completed annually.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request with weekly checks and balances being verified.</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 the recommended range.</p> <p>Good prescribing practices noted included 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 was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There was only one resident who was self-administering medicines at the time of audit (the resident is currently in the WDHB). Appropriate processes were in place to ensure this is managed in a safe manner.</p>

		There is an implemented process for comprehensive analysis of any medication errors.
<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 one of two cooks and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and had been reviewed by a qualified dietitian in December 2017 and was being reviewed at the time of this audit.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service has a food control plan and this was audited by the Auckland City Council and expiry will be 22 January 2020 as displayed. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All cooks and kitchen assistants have completed safe food handling.</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. There are two main cooks who cover the week and are supported by kitchen hands. All meals are prepared on site and served directly to the residents in the main dining room.</p> <p>Evidence of resident satisfaction with meals was 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 family/whānau is managed by the organisation, where appropriate.</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. 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 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.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale and challenging behaviour, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments. There are two registered nurses plus the clinical nurse manager. However, there are only two registered nurses and</p>

manner.		one in training who are competent to complete the required assessments. Residents and families confirmed their involvement in the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>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 the momentum care plans reviewed.</p> <p>Care plans evidenced 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. Examples of short term care plans were observed such as for pyrexia, wound care and/or urinary tract infections (UTI). Residents and families reported participation in the development and ongoing evaluation of care plans.</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>Documentation, observations and interviews verified the care provided to addressed resident's individualised needs was evident at this rest home. The GP interviewed verified that medical input is sought in a timely manner and that medical instructions were followed and care provided was of a high standard. Caregivers interviewed 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.</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>	PA Low	<p>The activities programme is provided by a diversional therapist (DT) who has been at the facility since January 2019. The DT is employed Monday to Friday 9am – 3.30pm and an activities coordinator works on Friday, Saturday and Sunday 9am to 3.30pm. Van outings are arranged on the Fridays as there are two staff on duty.</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 three monthly and as part of the formal six- monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme very interactive and fun also stating that they are supported in individual specific activities of interest they have. There are two residents who are</p>

		<p>under 65 years of age. Activities are planned individually to ensure the two residents' needs are able to be effectively met. Activities attendance records are maintained by the diversional therapist and the activities provided are recorded as well.</p> <p>Residents in the rest home are fully supported to participate in the weekly Friday van outings into the community. Specific outings are arranged such as taking one resident to the returned services association weekly for a meal. The activities programme is planned monthly but displayed weekly in all service areas. The residents are provided with a copy for their individual rooms. A church service is held every Friday morning. Birthdays and special events are celebrated. Additional resources will be needed when hospital level residents are admitted to the facility as required.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN or senior registered nurse.</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, weight loss and trialling of restraint. When necessary, and for unresolved problems, long term care plans are added to and updated. 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>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'resident doctor', residents may choose to use another medical practitioner with some residents supported by one other GP. 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 a speech language therapist, physiotherapist, diabetic or wound nurse specialists, breast clinic, radiology, skin clinic, ophthalmology clinic, radiology and/or the dietitian. 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 Waste And Hazardous</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who handle chemicals have completed education related to safe chemical handling. Material safety data sheets were available</p>

<p>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>where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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>	FA	<p>A current building warrant of fitness (expiry date 28 May 2020) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment (June 2019) and calibration of bio medical equipment (July 2019) was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Repairs and maintenance is undertaken by maintenance staff with contractors being used for the upgrade and refurbishment of rooms. Residents and family stated that they were happy with the environment. Positive comments were gained related to the environmental upgrades in the residents' satisfaction survey carried out in June 2019.</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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes all bedrooms having full ensuite facilities and one large bathroom in the common area. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. As each wing is being upgraded this includes refurbishment of ensuite bathrooms.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed</p>	PA Low	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. At the time of audit all bedrooms are single occupancy. The provider is aware that approval must be sought for bedrooms to be shared. Rooms are personalised with furnishings, photos and other personal items displayed.</p>

<p>areas appropriate to the consumer group and setting.</p>		<p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> <p>Whilst much of the remedial work required to meet this standard (as identified in the partial provisional audit report) has been completed, work to one of the lifts in A wing is yet to be completed and therefore this criterion attainment remains partially achieved.</p> <p>Access to room 1 and room 6 has been completed.</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. The dining and lounge area is delineated by the use of flooring and furnishings. The areas have been upgraded and refurbished to ensure they meet resident needs. They provide easy access for residents and staff. Residents can access areas 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 in a dedicated laundry. The dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. With the exception of one resident identifying in the resident satisfaction survey that they had one item of lost clothing, all residents at the time of audit reported the laundry is managed well and their clothes are returned in a timely manner. The laundry has been enlarged and refurbished to cater for the advent of hospital level care residents. This was a finding in the partial provisional audit and is now fully attained.</p> <p>There is a small designated cleaning team who have received appropriate training in safe chemical handling. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>leaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The Ministry of Civil Defence and Emergency Management recommendations for the region are met related to appropriate stocks of water and food. The 1000 litre emergency water tank is located in the grounds. There are also adequate supplies of blankets, mobile phones, alternative cooking such as gas BBQ if required for</p>

<p>situations.</p>		<p>use in the event of a civil defence emergency. Stocks sighted meet the requirements for 55 residents.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 22 May 2002 and no changes have been made to the footprint since this time.</p> <p>A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 19 February 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. The call system is currently being upgraded to allow the room number of where the call bell has been activated. This shows in the nurses' station and in the dining room. It is connected to staff pagers. Residents and family reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at night as part of staff duties.</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 comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and 33 bedrooms have a ranch slider door that opens onto outside gardens or a small patio area. Heating is provided by electric heater in residents' rooms with a large gas fire in the lounge area. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<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>	<p>FA</p>	<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 with input from the contracted laboratory service and the general practitioners who visit the facility. The infection prevention and control programme and policies and procedures are reviewed annually. The review occurred on 22 January 2019. Information is accessible to staff.</p> <p>The clinical nurse manager is the designated IPC coordinator whose role and responsibilities are defined in a job description reviewed. Infection control matters including infection surveillance results are reported monthly to the clinical manager and tabled at the quality meeting. Feedback is provided to the staff as required.</p> <p>Signage is available and used appropriately. Visitors are advised that if they are unwell not to enter the facility. The infection control manual guides staff about how long they must stay away from work if they</p>

		have been unwell. Staff interviewed understood these responsibilities and the principles of infection prevention and control.
<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 infection control coordinator has appropriate skills, knowledge and qualifications for the role and has been in this role for five years or more. The programme is overseen by the clinical manager. Relevant study days have been attended as verified in the staff training records reviewed. Additional support and information is accessible through the general practitioners and/or the infection control team at the DHB, the microbiologist at the contracted laboratory and/or the public health service. The clinical nurse manager is supported by the senior registered nurse and both are able to access residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The ICC confirmed the availability of resources to support the programme and any outbreaks of an infection.</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 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>	FA	<p>The policies and procedures reviewed reflected the requirements of the infection prevention and control standard and evidences current good practice. Policies were last reviewed 22 January 2019 and included the laundry, cleaning, kitchen and care delivery. All services follow the required organisational policies such as use of hand-sanitisers, good hand-washing techniques and use of disposable personal protective resources such as gloves and aprons. Staff verified knowledge of infection control policies and practices when interviewed.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation when newly employed and that training is ongoing. Education is provided by the clinical nurse manager/ICC and the senior registered nurse. The team leader/caregiver interviewed shares her knowledge with care staff as well during orientation of new staff. Training is recorded and evaluated to ensure it is relevant, current and understood by the care staff. There have been no outbreaks of infection since the previous audit.</p> <p>Education with residents is generally on a one-on-one basis and has included reminders about handwashing and advice when the residents are unwell. Discussions are held at the staff meetings</p>

		when relevant.
<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>	FA	<p>Surveillance is appropriate for the size and nature of this aged residential care facility. Surveillance includes infections such as urinary tract, soft tissue, fungal, eye, gastro-intestinal, upper and lower respiratory tract and skin conditions. The ICC reviews all reported infections and these are documented. The contracted laboratory also prints out all infections and any antibiotics used by the general practitioners. New infections and any required management plan is discussed at handover to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify if any trends exist, possible aetiology and any actions required. Results of the surveillance programme are shared with staff via the staff meetings and at staff handovers between the shifts. Graphs are produced by the assistant manager that identify trends for the coming year and comparisons against previous years and this is reported to the clinical nurse manager and to management monthly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 restraint coordinator (senior registered nurse) provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities.</p> <p>On the day of audit, no residents were using restraints. Six residents were using enablers, which were the least restrictive and used voluntarily at their request. All residents using enablers had signed consent stating they were voluntary. Enabler use is identified on residents' care plans.</p> <p>The restraint coordinator stated that restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</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>	PA Low	<p>Policy identifies the required service provider levels and skill mixes required to provide safe service delivery. This was confirmed during a review of rosters and during interviews with staff members. Residents and family confirmed staff are always available. The facility gained approval to provide hospital level care the day prior to audit but on the days of audit all residents were receiving rest home level care. The previous partial provisional audit identified that prior to the commencement of hospital level care services being offered the service must implement the correct skill mix which requires 24 hour, seven days a week registered nurse cover. This attainment remains unmet. The need for more staff is understood by the owner/director and members of the management team and is identified in the projected roster sighted. The service is adequately staffed for the current rest home level care residents.</p>	<p>The service does not have 24 hour, seven day a week registered nursing cover and therefore they cannot commence hospital level care until this requirement is met.</p>	<p>Ensure that the facility is adequately staffed to meet the increased requirements of residents who are assessed as hospital level care.</p> <p>Prior to occupancy</p>

				days
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>Activities are planned and provided to develop and maintain strengths (skills, resources and interests) that are meaningful to residents. Additional time and resources will be required for the hospital level residents authorised to be admitted to this facility. One-on-one activities will need to be provided to hospital level residents who cannot join in the group activities.</p>	<p>Additional resources will be required for hospital level care residents in view of activities to be provided for hospital level residents.</p>	<p>Ensure additional resources and one-on-one time is able to be allocated when hospital level care residents are admitted.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.4.1</p> <p>Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely maneuvers with the assistance of their aid within their personal space/bed area.</p>	PA Low	<p>One lift in A wing which will be used for hospital level care residents is currently being upgraded but the work is not completed. The general manager/facility manager stated the are seeking advice from lift installation companies to work out how this can best be made compliant. They are aware that this work must be completed prior to the upstairs A wing hospital level care beds being occupied.</p>	<p>One lift in A wing which will be used for hospital level care residents is currently being upgraded but the work is not completed. The general manager/facility manager stated the are seeking advice from lift installation companies to work out how this can best be made compliant. They are aware that this work must be completed prior to the upstairs A wing hospital level care beds being occupied.</p>	<p>Ensure the lift that is to be used for the transportation of hospital level care residents in A wing is upgraded to comply with current legislation and that it can be used to safely move residents around as required.</p>

				Prior to occupancy days
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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.