

Blockhouse Bay Healthcare Limited - Blockhouse Bay Home

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: 28 November 2017 End date: 28 November 2017
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:	26

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Blockhouse Bay Home provides rest home level care for up to 43 residents. The service is privately operated and managed by a clinical nurse manager who is a registered nurse. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a contracted mental health provider. The general practitioner was not available for interview.

This audit identified three areas requiring improvement relating to documentation in progress notes, management of self-administration of medications and kitchen cleaning. Improvements have been made to interRAI assessments, with all being current at the time of this audit, addressing the previous area requiring improvement.

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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Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent. Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination. 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.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, goals, values and mission statement of the organisation. Monitoring of the services occurs and information is provided to the owner/director at least quarterly and covers all areas of service delivery. 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.

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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The multidisciplinary team, including a registered nurse and general practitioner assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness.

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 policies and procedures that support the minimisation of restraint. No individual enablers or restraints were in use at the time of audit. Environmental restraint is documented in policy. Policy includes required documentation covering assessment, approval and monitoring process should restraint be implemented. Use of enablers is described in policy as voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	3	0	0	0
Criteria	0	36	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints and concerns 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.</p> <p>The complaints register reviewed showed that four complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The clinical nurse manager (CNM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>In August 2016, concerns raised by Auckland Hospital were investigated by the Auckland District Health Board (ADHB) quality and monitoring manager, and an action plan put in place has been completed by Blockhouse Bay Home and signed off as completed. The improvements made include better use of short term care plans, updating of policy and procedures related to post falls management and additional fall prevention training provided for staff.</p>
Standard 1.1.9: Communication	FA	Residents and family members stated that 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

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		<p>and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure and that residents have a right to full and frank information and open disclosure from service providers. This was supported by policies and procedures that meet the requirements of the Code. Language and communication needs and use of alternative information and communication methods are available and used where applicable to support young people with disabilities.</p> <p>Interpreter services are able to be accessed via the DHB when required. Staff knew how to do so, although reported this was rarely required due to family and staff who can provide interpretation as and when needed. Staff represent many nationalities in the workplace.</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>	FA	<p>The strategic and business plans, which are reviewed annually and monitored quarterly, 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 quarterly meetings of the quality group, which the owner/director attends, showed adequate information to monitor performance. The review covers strategic goals, medication errors, falls, infections, challenging behaviour, hospital admissions and quality data. Any anticipated problems or challenges are discussed and preventative actions shown.</p> <p>The service is managed by a clinical nurse manager (CNM) who holds relevant qualifications and has been in the role for five years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CNM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing education both on-site and off-site.</p> <p>The service holds contracts with Auckland District Health Board (ADHB) and the Ministry of Health (MoH). The ADHB contract is the Age Related Residential Care contract and 24 residents were receiving services under the contract, two were respite care. The MoH contract is the Residential Non Aged Care contract and two residents were under this contract at the time of audit. The service also holds an ADHB contract for Long Term Support – Chronic Health Conditions but no residents were under this contract at the time of audit.</p> <p>There are two independent boarders at the facility who receive hotel services only.</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</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, audit activities, twice yearly patient/family satisfaction surveys, monitoring of outcomes, clinical incidents including infections and skin tears. Quarterly benchmarking of quality data is undertaken by an off-site provider. The results indicate that Blockhouse Bay results are below average when compared with other like type facilities.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related</p>

<p>that reflects continuous quality improvement principles.</p>		<p>information is reported and discussed at the quality review team meetings and at monthly staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and implantation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. These are documented in staff meeting minutes and on incident and accident forms. Corrective actions for complaints are documented on specific forms kept with the complaints management data.</p> <p>Resident and family satisfaction surveys are completed twice a year in January and July. The most recent survey showed satisfaction with services provided. All negative comments, of which there were three, were followed up. For example, one resident who wanted a particular change to one ingredient in the menu was followed up. When asked if they would like an individual menu they declined.</p> <p>Policies reviewed covered 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 by an off-site provider and based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The CNM and health and safety representative (administrator) described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. This was confirmed in the documentation sighted. The owner/director is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. An improvement has been made related to post falls assessment to ensure all unwitnessed falls or falls with head injuries have neurological observations taken and documented. Family are notified of incidents and accidents as appropriate.</p> <p>Adverse event data is collated, analysed and reported on at quality review meetings and staff meetings. This was confirmed in documentation and meeting minutes sighted.</p> <p>The CNM described essential notification reporting requirements. (The form related to pressure injury reporting of grade three and above was downloaded at the time of audit and added to procedure documentation should it be required for future use). The CNM 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 to public health.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after six weeks, and then annually. The CNM stated this would be undertaken sooner if there were any concerns with a staff member's performance.</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. Currently one staff member is level four, one is level three, the cleaner is level two and all other care staff have commenced the required study. A staff member is the internal assessor for the programme.</p> <p>The CNM is a trained and competent registered nurse who maintains their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<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. The facility adjusts staffing levels to meet the changing needs of residents. InterRAI information is used when deciding on staffing mix and levels. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of four weeks' rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p> <p>The CNM works five days a week Monday to Friday, the diversional therapist works 8.30am to 4.30pm Monday to Friday, administration staff 10am to 6pm, cook 7am to 3pm and kitchen assistant 4.30pm to 8.30pm. At night there is one caregiver and one caregiver 'sleep-over' who is available for assistance as required.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA Low	<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>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</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.</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 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 include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, were current and comply with guidelines.</p> <p>There is one resident who was self-administering medications at the time of audit, however the facility was unable to provide documentation showing that the resident is competent to do so.</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>PA Low</p>	<p>The food service is provided onsite by a cook, and is in line with the recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has recently been reviewed by a qualified dietician this year.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with the current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification. The service at the time of audit was not aware of the requirements of the new Food Act (2014) and the need to have an approved food safety plan and deadline of March 2018, however by the end of audit, had accessed the appropriate information.</p> <p>A cleaning schedule was sighted but did not provide sign off as being completed by night staff. Observation of the kitchen at the time of audit showed that cleaning was not being completed.</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</p>

		<p>known to the kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. The 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 1.3.6: 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 provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP was unavailable at the time of audit for interview. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels 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>	FA	<p>The activities programme is provided by a trained diversional therapist holding the national certificate in diversional therapy.</p> <p>A comprehensive social assessment and history is taken on admission to ascertain residents' needs, interests, abilities and social requirements. Activity assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. There are regular outings for the residents and young people with disabilities with a hired van. Residents attend community events on a weekly base. The resident's activity needs are evaluated monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect the resident's goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and family are involved in evaluating and improving the programme through satisfaction surveys and residents' meetings. Residents interviewed confirmed they find the programme sufficient.</p>
<p>Standard 1.3.8: Evaluation</p> <p>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, however this information is not summarised in the progress notes by the registered nurse (Refer criterion 1.3.3.4).</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 and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whanau</p>

		interviewed were able to provide examples of involvement in evaluation of progress and any resulting changes.
<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	A current building warrant of fitness (expiry date 24 June 2018) is publicly displayed.
<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 to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, mouth, eye/ear/nose, gastro-intestinal track, the upper and lower respiratory tract and wounds. The clinical nurse manager is the infection prevention and control (IPC) coordinator and reviews all reported infections, and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared at staff meetings, at staff handovers and to the owner. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked externally within an external provider.</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 (CNM) provides support and oversight for enabler and restraint management in the facility, should that be required. They demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. On the day of audit, no individuals were using restraints or enablers. Enablers, are identified in policy as the least restrictive and used voluntarily at the resident's request.</p> <p>The service has environmental restraint owing to a key pad locked door between the reception area and resident area. This is for safety only as the reception area is not manned at all times. This is identified and managed according to policy.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	At the time of audit, there is one resident who is self-administering medicines. As per the facilities policy the RN has evidenced that the resident is asked weekly if they have taken their medication and this was recorded. The three-monthly GP review of the resident's medications and health status is up to date. In discussions with the resident and staff, it was evident that the resident is competent in the self-administering of their medication however the assessment to acknowledge the resident's ability to self-medicate has not been updated and reviewed since 2015.	One resident who is self-medicating has not had an updated medication review since 2015.	Provide evidence to show that the resident is competent in self-administration of medicines. 60 days
Criterion 1.3.13.5 All aspects of food procurement, production,	PA Low	The residents and families interviewed stated that they were very happy with the meals provided. The cook interviewed stated that they clean the kitchen daily and two nights a week (Tuesday, Thursday) the night staff clean the kitchen completing the bigger tasks such as cleaning of the equipment and washing of the floors. A cleaning schedule was sighted; however, there was	The cleaning schedule sighted is not signed off as completed by	Provide evidence that required kitchen cleaning is

preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		no evidence that the schedule was being implemented and signed of as completed. At the time of the audit and in observation the kitchen floor required cleaning.	night staff.	undertaken as per schedule. 180 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Low	It was evident from staff and clinical nurse manager/RN interviewed that they knew the residents well. Family/whanau interviewed stated that they were happy with the care and communication provided. The progress notes written by the care givers are documented well, However, the registered nurse does not summarise, or sign of at least weekly progress notes completed by caregivers	The registered nurse does not complete a documented weekly summary and sign of resident's progress notes written by caregivers.	<p>Provide evidence that progress notes written by caregivers have a documented signoff by the registered nurse at least weekly</p> <p>180 days</p>

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.