

# Blockhouse Bay Healthcare Limited - Blockhouse Bay Home

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Blockhouse Bay Healthcare Limited

**Premises audited:** Blockhouse Bay Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 20 June 2019 End date: 21 June 2019

**Proposed changes to current services (if any):** The service has undertaken a reconfiguration of service beds. They have added a new 40 bed hospital and rest home. As 19 of the old service beds have been demolished. This takes the total number of beds to 64 in total, 14 of which are existing rest home level care beds. The reconfiguration is also requesting the additional of Hospital - Medical and Hospital - Geriatric services.

**Total beds occupied across all premises included in the audit on the first day of the audit: 25**

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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 currently provides rest home level care. The service is one of two privately owned and operated by the same providers. It is managed by a registered nurse (manager). The service is in the process of completing a new build which contains 40 bedrooms for rest home and hospital level care residents. As they have demolished 19 rest home level care rooms leaving a total of 24 rooms this will take the total number of beds to 64. Residents and families spoke positively about the care provided.

This certification and partial provisional audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board and Ministry of Health. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, one owner/director and a general practitioner.

The service has been assessed to provide the addition of hospital medical and hospital geriatric service level of care.

This audit has identified 13 areas requiring improvement. Six of these relate specifically to the new build which is to offer dual purpose beds offering rest home and hospital level care services. The improvements found relate to the fire evacuation scheme, the completion of the internal environment, external physical environment, building plant and equipment, the appointment of appropriate service providers and medication management. Seven relate to current services including night duty staffing levels, all stages of service provision being undertaken by a registered nurse, assessment, consistency of care planning, labelling of chemicals, maintenance of toilet and shower areas and infection control.

One bedroom in the new building is only suitable for rest home level care as it is too small to safely use lifting equipment. The other 39 bedrooms meet the requirements for dual purpose use.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Blockhouse Bay Home. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Blockhouse Bay Home provides services that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Blockhouse Bay Home has links with a range of specialist health care providers, enabling the provision of services to residents to be of an appropriate standard.

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

## Organisational management

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

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Morning and afternoon shift staffing levels and skill mix meet the changing needs of residents. A projected roster identifies that additional staff will be employed to meet standard requirements and residents' needs when the new beds are approved.

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a range of information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided meets their needs. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is run by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility vehicle is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall 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.		Some standards applicable to this service partially attained and of low risk.
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The current facility meets the needs of residents. There is a current building warrant of fitness for the existing building. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible to residents with shade and seating provided.

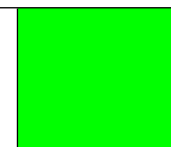
Policy describes how waste and hazardous substances are managed. Staff use protective equipment and clothing. Soiled linen and equipment are safely stored. Laundry is undertaken onsite.

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

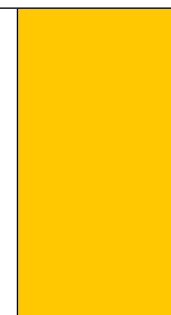


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of the audit. Use of enablers is voluntary for the safety of residents in response to individual requests. One restraint was in use. A comprehensive assessment, approval and monitoring process occurs. Policy identifies that regular reviews will occur. 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.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The infection prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the Auckland District Health Board. The programme is reviewed annually.

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

Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked 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	39	0	6	5	0	0
Criteria	0	88	0	8	5	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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Blockhouse Bay Home has policies, procedures and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>Nursing and care staff interviewed understand 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 including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the residents' files. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents and their family members are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. 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>Staff were aware of how to access the Advocacy Service.</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>	FA	<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' families and friends. Residents were observed going in and out of the facility freely. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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>	FA	<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.</p> <p>The complaints register reviewed showed that two 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 showed any required follow up and improvements have been made where possible. The RN manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints 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>	FA	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and family members of residents confirmed that Blockhouse Bay Home provides services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the GP. All residents except for a married couple, have a private room. The married couple share a room at their request.</p> <p>Residents are encouraged to maintain their independence and participate in a wide range of community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each resident's care plan reviewed included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Apart from those records referred to in criterion 1.3.5.2, records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</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>	FA	<p>There are four residents in Blockhouse Bay Home at the time of audit who identify as Māori. Observation, documentation (except for that referred to in criterion 1.3.5.2) and interviews verified staff can support residents 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 to Māori residents. There is a current Māori health plan developed for all residents who identify as Maori.</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>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents' personal preferences, required interventions and special needs were included in care plans reviewed. Specific cultural food requirements are catered for. The resident satisfaction survey confirmed that individual needs are being met. Interviewed staff demonstrated understanding and knowledge on providing culturally safe services to residents.</p>

Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. Records of completion of ongoing training on professional boundaries and elder abuse and neglect were sighted in reviewed staff files. 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, mental health services for older persons, Maori mental health services and renal services. Cluster meetings are held with the gerontology specialist nurse quarterly. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Interviewed relatives gave positive feedback on effective communication from the nursing team.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Records of training were sighted in reviewed staff files.</p> <p>Other examples of good practice observed during the audit included treatment protocols in place based on evidence-based rationales, which are monitored and evaluated.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members of residents stated they were kept well informed about any changes to their own or 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. There was also evidence of resident/family/ support worker input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via Auckland District Health Board (ADHB) when required. Staff knew how to do so, and brochures on the service were easily accessible.</p>
Standard 1.2.1: Governance The governing body of the	FA	The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of quarterly reports to the owner/director showed adequate

organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		<p>information to monitor performance is reported including occupancy, quality data, staffing, internal audits, policy updates, minutes of residents' meetings, health and safety, emerging risks and issues. The planning included actions to be taken related to occupancy of the new build.</p> <p>The service is managed by a registered nurse who holds relevant qualifications and has been in the role for eight years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The RN manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing education and attendance at off-site meetings related to aged care management.</p> <p>The service holds contracts with Auckland District Health Board (ADHB) for rest home level care and the Ministry of Health for persons under the age of 65 years for rest home level care.</p> <p>On the days of audit there were 25 residents. Two residents were receiving services under the Ministry of Health Non-Aged Long Term contract, one resident was under ADHB Long Term Rest Home (this resident was under 65 years) and 22 residents were receiving care under the ADHB Age Related Residential Care contract.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the owner/director is absent, the RN manager carries out all the required duties under delegated authority. During absences of the RN manager, the clinical management is overseen by a registered nurse from the facility's sister site 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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, wounds, skin tears, falls 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 management service reviews and the staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and the implementation of corrective actions. Corrective actions are developed and implemented to address any shortfalls. For example, the food internal audit identified that unwrapped food was left in the fridge. The</p>

		<p>corrective action shown identified that the kitchen staff were informed and close monitoring occurred to ensure all food was covered when placed in the fridge.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (September 2018) did not identify any areas of concern. The RN manager stated that if any concerns were raised actions would be taken to resolve any concerns.</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 based on best practice and were current. The clinical policies are adequate for the management of hospital level care residents. 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 RN 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. This was confirmed in documentation sighted.</p> <p>Both the owner/director and the RN manager confirmed that the current quality and risk system will be implemented to include residents admitted to the new unit.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the RN manager and to the owner/director. Information is used to make improvements to the service where appropriate.</p> <p>The RN 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 or any other external body since the previous audit. During interview the RN manager confirmed their understanding of reporting requirements.</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</p>	PA Low	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of</p>



the requirements of legislation.		<p>completed orientation and a performance review after a six-month period with ongoing annual reviews which were up to date.</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 is the internal assessor for the programme. The education programme includes staff attendance at the ADHB study days and on-site guest speakers. A review of the content of education offered identifies that it is of a level to allow staff to be knowledgeable about hospital level care service requirements.</p> <p>Only the RN manager is trained and competent to undertake interRAI assessments. They maintain their annual competency requirements to undertake interRAI assessments. The current competency review expires in March 2020.</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>	PA Moderate	<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). Observations and review of a six-week roster cycle was undertaken. This confirmed staff are replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. However, safe staffing levels according to policy are not followed for night duty. Policy states that for the number of residents there will always be at least two care staff on duty. Rosters identified that there is only one rostered care staff member from 11pm to 7am with a 'sleepover' staff member available if required. Night staff confirmed they wake the sleepover staff member to assist with cares for residents who require two people.</p> <p>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.</p> <p>Staffing levels meet the interRAI acuity level report findings as all current residents are receiving rest home level care.</p> <p>The RN manager, administrator/maintenance person and diversional therapist work Monday to Friday full time and they are all on call. The kitchen is staffed 7am to 3pm seven days a week. One dedicated cleaner works five hours per day, seven days a week.</p> <p>There is projected roster for the opening of the new beds which showed how staffing levels will increase incrementally as resident numbers increase.</p>
Standard 1.2.9: Consumer	FA	The resident's name, date of birth and National Health Index (NHI) number are used on labels as the

<p>Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</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>	FA	<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. NASC assessment documents were sighted in the reviewed residents' files. 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 facility brochure and welcome pack has clear information on services provided for residents, their family/whanau, where appropriate, local communities and referral agencies. Inquiry information is recorded, and outcomes documented regularly. 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 on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. Entry to service is facilitated by the nurse manager and the nursing team.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the ADHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine</p>	PA Low	<p>The medication management policy is current and identifies all aspects of medicine management in line</p>

<p><b>Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by two senior healthcare assistants against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>There are no controlled drugs stored or in use at the time of audit, however observations and interviews when required these are able to be managed in a safe manner.</p> <p>The records of temperatures for medicines stored in a plastic container in the kitchen fridge, demonstrated that temperatures 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 being met. The required three-monthly GP review was consistently recorded on the electronic medicine chart. The GP stated healthcare assistants assist the GP with medication reviews.</p> <p>There were two residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>Medication errors are reported to the RN and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p> <p>There is no plan in place regarding how medications will be managed with the increased resident numbers in the new unit.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian on the 18 February 2019. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the Auckland Council. An audit was undertaken 29 May 19 and resulted in an 'A' grade certificate being awarded.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal</p>

		<p>comply with 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, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p> <p>To accommodate the addition of an extra forty residents, the kitchen has been extended (refer criterion 1.4.2).</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 no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. With the exception of that referred to in criterion 1.3.5.2, 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 with the nurse manager and records were sighted in reviewed files. Where entry is declined, the referring agency, resident and/ family are advised of the reasons for declining entry and documentation of this was sighted in the inquiries book. 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 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Moderate	<p>On admission, residents of Blockhouse Bay Home are initially assessed by senior Healthcare assistants, using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed by the RN, using the interRAI assessment tool. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require. Six of the eight files reviewed however, had an InterRAI assessment that was inconsistent with the needs of the resident, and this requires attention.</p>

		In all files reviewed, initial assessments are completed within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA</p> <p>Moderate</p>	<p>Care plans reviewed did not always reflect fully the support needs of residents. This included the needs identified by the interRAI assessment and other relevant clinical information and this requires attention.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. 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>	<p>FA</p>	<p>Apart from that referred to in criterion 1.3.5.2, documentation, observations and interviews verified the provision of care to residents was consistent with their needs. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner. Healthcare assistants participate in the medical rounds when the GP visits and medical orders are followed. The GP was complimentary of the care provided by the healthcare assistants. Care staff confirmed that care was provided as the resident required, however this was not always documented in the care plan. (Refer criterion 1.3.5.2) 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>	<p>FA</p>	<p>The activities programme at Blockhouse Bay Home is provided by a trained diversional therapist Monday to Friday holding the National Certificate in Diversional Therapy.</p> <p>A social assessment and history are 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 regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included exercise programmes, walks, visiting entertainers, quiz sessions and daily news updates. Several residents attend local community programmes offered by support agencies in the region.</p>

		<p>Residents were observed to be coming and going all day. The activities programme is discussed at the minuted residents/family meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the activities programme. Residents interviewed confirmed they find the programme meets their needs.</p> <p>To meet the needs of forty additional hospital residents, the proposal includes an increase in activities staff. The new building includes space for activities to take place. The present rest home vehicle is not able to transport residents with restricted mobility; however, the facility hires the local mobility taxi when their services are required and the use of this service will increase.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Apart from that referred to in criterion 1.3.5.2, where progress is different from expected, the service responds by initiating changes to the plan of care. Examples are sighted of short-term care plans being consistently reviewed for infections, pain, and weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. 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)</p> <p>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 main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. The service is well supported by community support groups, who respond promptly when required. Copies of referrals were sighted in residents' files, including to older persons' mental health services, and Maori mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family 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. The cleaner has completed safe</p>

<p><b>Substances</b></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>chemical handling education. Material safety data sheets were made available where chemicals are stored at the time of audit. Staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of aprons, gloves and gowns (PPE) and staff were observed using this. However, no PPE was available in the current sluice room. Refer to comment in criterion 3.2.1 which also relates to equipment in the sluice room.</p> <p>The service will make personal protective clothing and equipment available in the new build.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>A current building warrant of fitness for the existing building (expiry date 24 June 2019) is publicly displayed. The code of compliance certificate is yet to be obtained for the new building.</p> <p>Appropriate systems are in place to ensure the current residents' physical environment and facilities are fit for their purpose and maintained. Residents confirmed they are happy with the environment. The testing and tagging of electrical equipment (June 2019) and calibration of bio medical equipment (April 2019) is current as confirmed in documentation reviewed, interviews with the maintenance person and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. The new building has adequate storage areas.</p> <p>External areas are safely maintained around the old part of the building but are yet to be completed for the new part of the building.</p> <p>The internal physical environment in the new building needs to be completed to ensure it safely meets residents needs and that independence is promoted. For example, the all areas need to be appropriately equipped, furnished and completed to meet all requirements.</p> <p>The current laundry equipment of one small washing machine and one dryer is not adequate to cater for the additional number of hospital level care residents. (The owner/director stated he is considering sending large laundry items off site).</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending</p>	PA Low	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The existing building has a toilet and hand basin which are shared between two bedrooms for 22 rooms. One bedroom has a toilet which is screened off using shower curtains for privacy. The RN stated the toilet was in place when she commenced employment. The resident is very happy with the toilets placement. Other toilet areas are located centrally in each wing. One toilet and one shower require maintenance to ensure good infection control standards can be maintained.</p>

to personal hygiene requirements or receiving assistance with personal hygiene requirements.		The new build has ensuite facilities with the exception of one bedroom. Five ensuites do not have showers. Shower and toilet areas are also located on each floor to include a disability facility and a visitor toilet. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. The existing build has 23 bedrooms which are single accommodation and one bedroom which is shared by a husband and wife as they requested. This sharing of the bedroom occurred in May 2019. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>The new building bedrooms are adequate to provide residents and staff to move around safely. The door width allows equipment to be used safely. One bedroom (room 24) is much smaller than the other 39 rooms and on the day of audit a demonstration was undertaken to show that a lifting hoist could not be safely used in this room. Therefore, only 39 bedrooms are suitable for dual purpose and room 24 needs to be for rest home level care only.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The existing building has a shared dining and lounge area which enables easy access for residents and staff. Residents can access their bedrooms for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> <p>The new building has two large lounge areas and one will be used for dining and lounge and the other for lounge only. Refer to comments in 1.4.2 regarding the need to furnish these rooms prior to occupancy.</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</p>	PA Low	<p>Laundry is undertaken on site in a small dedicated laundry which is suitable for the current number of rest home level care residents but it may be too small to cater for 64 residents which are to include hospital level care residents. The owner/director stated they would use off site laundry services as required to cater for additional laundry needs as resident numbers and levels of care increase. Refer to comments in criterion 1.4.2.4 related to laundry equipment.</p> <p>Care staff undertake the laundry as part of their everyday work and they demonstrated a sound</p>



being provided.		<p>knowledge of the laundry processes. Residents interviewed reported that currently the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is one dedicated cleaner who has completed the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview and sighted in training records. Refer to comments in standard 1.2.8 regarding days worked. Chemicals were stored in secure areas, but they were not all labelled.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. This process will continue for the new building.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff for the existing building. 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 current fire evacuation plan was approved by the New Zealand Fire Service on the 13 June 1994. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 24 January 2019 with no follow up required. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, and gas BBQ's were sighted and meet the requirements for the 25 residents and the Ministry of Civil Defence and Emergency Management recommendations for the Auckland region. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. There are 14 close circuit cameras located in common areas which include the new building, the exit doors and in the car park. These are monitored from the nurses' station and the owner/directors cell phone.</p> <p>The new building is fully equipped with sprinklers and hard wired smoke alarms which are connected to the fire service to meet legislative requirements. A copy of the fire evacuation plan has been sent to the fire service and is awaiting approval.</p> <p>The administrator/maintenance person will ensure that that adequate emergency supplies in the event of a civil defence emergency to include water will be available for the number of residents in the facility.</p> <p>On the day of audit two of the new bedrooms had usable call bells and the other call bells throughout the new facility were being connected by an approved contractor. The call bells will be monitored</p>

		electronically when they are completed. Refer to requirements under criterion 1.4.2 related to call bells.
<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>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by underfloor heating in residents' rooms and in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p> <p>The new building has heat pumps in all residents' bedrooms and in the common areas. The upstairs windows have security stays on them to prevent them from opening too wide. The downstairs bedrooms, some of which have ranch sliders with direct outdoor access are required to be ramped. Refer comment in criteria 1.4.2.6.</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>	FA	<p>Blockhouse Bay Home provides a managed environment that aims to minimise the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme.</p> <p>The infection control management at Blockhouse Bay Home is guided by a comprehensive and current infection control manual, developed at organisational level with input from the clinical manager. The infection control programme and manual are reviewed annually.</p> <p>The clinical manager is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the staff meetings. Infection control statistics are collected and compared with previous months data.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p> <p>The present IPC programme will be able to accommodate extra residents at hospital level care.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	PA Moderate	<p>The infection control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role. The ICC has undertaken post graduate training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection</p>

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		<p>control team at the DHB are available and expert advice if needed. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The present sluice room in use does not provide ease of access to personal protective equipment when staff are required to deal with soiled linen.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection.</p> <p>A new sluice room is being built in the new area, to accommodate the additional residents, however it is yet to be equipped. (refer criterion 1.4.2)</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 IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Apart from that referred to in criterion 3.2.1, care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RN's and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Surveillance data is entered in the organisation's infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>Infection rates are low. There has been no Norovirus outbreak at Blockhouse Bay Home in the past seven years.</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 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 their role and responsibilities.</p> <p>On the day of audit, one resident was using a bedside rail restraint. No residents were using enablers. Policy identifies that enablers are the least restrictive and used voluntarily at their request.</p> <p>There is also a door which goes out into the main foyer which has a key-pad exit. This is documented as environmental restraint and is identified in policy. All residents and family members are made aware of this. The exit code number is clearly displayed. The door is kept locked for safety reasons as the layout of the facility does not always allow staff to sight who is entering the building.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the staff meeting minutes which includes restraint, and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint</p>	FA	<p>The restraint approval group is made up of the RN manager who is the restraint coordinator, the general practitioner and the team leader. The restraint approval group are responsible for the approval of the use of restraints and the restraint processes. This was confirmed in documentation sighted and in the resident's file. Policy is implemented around clear lines of accountability. The restraint in use was approved on 15 May 2019 and it is being monitored as per policy requirements which reflect the</p>

processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		<p>standard requirements.</p> <p>Evidence of the resident being included in the decision to use bedside rails is documented. The resident has no known family but the nominated EPOA was notified. (The resident has been in the facility since 1981). The use of restraint was not identified on the resident's care plan. Refer comments in criterion 1.3.5.2. All staff interviewed were aware of their responsibilities related to restraint monitoring.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessment for the use of restraint are documented and included all requirements of the Standard. The RN manager undertakes the initial assessment with input from the resident. The RN manager restraint coordinator described the documented process. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. The completed assessment was sighted in the notes of the one resident using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff, such as the use of sensor mats, low beds and behaviour management.</p> <p>Two hourly monitoring occurs for the one resident with restraint. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each six monthly restraint approval group meeting and monthly staff meetings. The register was reviewed and contained the resident currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. This was last presented in May 2019 by a guest speaker. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>There is a documented evaluation process which covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed. As the one using restraint has only been using the bedside rails for one month no completed evaluations have been undertaken. The RN manager stated evaluation will be implemented to meet</p>

		policy requirements.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The RN manager restraint coordinator confirmed that the restraint committee will implement policy related to the undertaking of a six monthly review of all restraint use which includes all the requirements of this Standard. It will include analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. Staff meeting minutes confirmed that no restraint had been used since the previous audit until May 2019 when bedside rails were placed on the resident's bed for safety reasons. Any changes to policies, guidelines, education and processes are implemented if indicated. Staff confirmed their understanding of restraint policies and procedures. The RN manager stated this is the first time they have used restraint in the eight years she has been at the facility. This is supported by documentation sighted in the restraint register and staff meeting minutes.</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 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	Currently the staff appointed are able to safely meet the needs of residents for rest home level care. As the new unit service delivery will include hospital level care, 24-hour registered nurse care must be provided and additional care staff must be employed. The RN manager confirmed their awareness of this.	Currently the RN manager is the only registered nurse employed and therefore 24-hour registered nurse cover cannot be maintained for hospital level care residents for the new unit.	<p>The service provides registered nurse care across the 24 hours, seven days a week period.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly</p>	PA Moderate	There is a documented process which determines service provider levels and skill mix. Policy states that there will be sufficient staff to meet the health and personal care	Only one care staff member is identified on the roster for night duty. There is a carer who does a	Provide evidence that all shifts are

documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.		<p>needs of all residents, at all times. It is clearly identified in policy that there will be at least one staff member on duty at all times if there are less than 10 residents and at least two staff on duty if there are more than 10 residents. The rosters reviewed showed that only one staff member is rostered each night with a sleep over staff member who can be called to assist if required.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed.</p> <p>The cleaner works seven days a week. When discussed with the owner/director they stated this is what the cleaner wished to do. The owner/director was advised that no staff member should work seven days every week without a rostered day off.</p>	<p>'sleepover' shift and who can assist if required. However, this does not meet policy requirements. The staff member who undertakes the sleepover is often rostered for a morning shift the next day or stays over following an afternoon shift. At the time of audit there are two residents who require two-person assistance, one for all cares including two hourly turns and one to mobilise. The cleaner works seven days a week with no rostered days off.</p>	<p>covered appropriately to meet policy requirements and to ensure resident care are delivered safely and that all staff have a rostered day off.</p> <p>30 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	The present medication management system is electronic, and this will be expanded to include the additional residents. The new unit on the ground level is an extension of the present rest home which has a small area to store medications and a medication trolley. The new extension on both ground and the upper level has space that can be used for managing medications. At this stage no decision has been made as to where medication will be delivered from and where it will be stored.	There is no plan in place of how medication will be managed in the new unit when resident numbers increase.	<p>Provide evidence that safe medication management systems are implemented to accommodate a larger number of residents.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.3.3.1</p> <p>Each stage of service</p>	PA Moderate	The RN undertakes all interRAI assessments, within the required timeframes. Six of eight files reviewed had the initial nursing assessments, pain, continence, pressure	Healthcare assistants are completing residents' initial care plans, initial assessments, ongoing	Each stage of service delivery is



provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.		injury and nutritional assessments and the care plans, completed by a senior health care assistant. No evidence verified this was with input from the RN. Interviews verified the staff member on duty when the resident is admitted, documents their assessment findings and the care the resident requires. Additionally, ongoing six-monthly clinical assessments are carried out by the health care assistant where required. Short term care plans are initiated by healthcare assistants. Behaviour assessments and Maori health plan assessments were being completed by the diversional therapist. Staff meeting minutes record 'thanks to the healthcare assistant for completing the care plans'.	assessments and care plans. The diversional therapist is completing the behavioural and Maori health plan assessments. These are not countersigned by the RN.	undertaken by the RN or there is evidence to verify that RN input has been provided.  60 days
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Moderate	<p>Six of eight files reviewed required an interRAI assessment to be in place to inform the care plan. The interRAI assessment for all of the six residents was able to be accessed on the computer and were completed in a timely manner. There was however no evidence in the care plan to verify the assessment summaries and the client summary report, was used to fully inform the care plan of these residents</p> <p>An interRAI assessment identified a resident as mobile, fully independent with eating and not restrained. The care plan, interviews with care staff and observation identified the resident was bed bound and required two hourly turns (refer criterion 1.2.8.1), full assistance was required with food and fluids, full assistance with all activities of daily living and was requiring the use of a restraint to prevent falls out of bed. An interview with the clinical manager concerning the high level of care this resident requires, identified the clinical manager was aware of the need for an update of the interRAI when a change in care level was required. The clinical manager was advised to update the interRAI and request a reassessment of care level.</p>	The needs of the residents were not accurately identified via the assessment process.	<p>Provide evidence residents needs are identified via the assessment process</p> <p>30 days</p>

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>A resident with a history of depression, recent input from the mental health team and a change in antidepressant medication, had no reference to depression and associated management strategies in the care plan.</p> <p>A resident identified in the care plan as independent with mobility was requiring two persons to assist with mobility. Increased staffing at night (refer criterion 1.2.8.1) was required to assist with mobilising this resident. A short-term care plan commenced by a healthcare assistant to manage an acute event for seven days, had no update or review when the timeframes had lapsed.</p> <p>A resident who identified as Maori and had a Maori health plan assessment, had no reference to cultural needs and associated management strategies in the care plan.</p> <p>A resident who self-administers an inhaler, had no reference to self-administration of inhalers in the care plan.</p>	<p>Care plans do not consistently describe fully the support the resident requires to achieve their desired outcomes.</p>	<p>Provide evidence that care plans describe the support the resident requires to meet their desired outcomes.</p> <p>60 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>The existing building has a current building warrant of fitness. Documentation confirms all legislative requirements are met.</p> <p>The new unit does not have a signed off code compliance certificate.</p>	<p>There is no code of compliance for the new building.</p>	<p>Provide evidence that the new building has a current code of compliance.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.2.4</p>	<p>PA Low</p>	<p>The existing building minimises the risk of harm, promotes safe mobility and aids resident independence</p>	<p>The new buildings physical environment is not completed and</p>	<p>Ensure the new buildings</p>

<p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>		<p>by ensuring the environment is safe and maintained to a safe standard. The extension to the existing kitchen which will enable the facility to cater for additional meals is yet to be completed. The current laundry equipment of one small washing machine and one dryer is not adequate to cater for the additional number of hospital level care residents. (The owner/director stated he is considering sending large laundry items off site).</p> <p>In the new building the sluice room needs to be equipped and operational. With the exception of two bedrooms, the emergency call bells are yet to be made operational.</p> <p>The lounge and dining room areas are not yet furnished. The lift is not operational.</p> <p>Resident lifting equipment is not available for the new build. (There is one lifting hoist which is used in the current rest home area).</p> <p>Thirty-eight bedrooms are yet to be furnished. (Two bedrooms had been furnished). The two nurses' stations (one on each floor of new build) are not yet outfitted.</p> <p>Hot water temperatures have not been checked for the new building.</p>	<p>appropriate equipment and furnishings are yet to be installed in all areas. The call bells are not activated throughout the new build; the lift is not operational. The kitchen extension is not completed. Laundry equipment is inadequate to cater for 46 residents and there is no working sluice area. The hot water temperatures has not been checked to ensure it is appropriate for use in an aged care facility.</p>	<p>physical environment is completed to promote safe mobility, aid independence and that residents needs can be met. Ensure hot water temperatures are appropriate.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.2.6</p> <p>Consumers are provided with safe and accessible external areas that meet their needs.</p>	<p>PA Low</p>	<p>The existing facility outdoor area is accessible and meets the current residents' needs.</p> <p>The new build gardens are not yet completed, and the walking surface is very uneven and unpaved. The bedrooms which have ranch slider access to the outdoors and the exit doors from the lounge area have a lip on them with a step to the outdoors. This would make entry and exit from these areas unsafe for residents who use mobility aids and it would be very difficult to manoeuvre a wheelchair across the door exits.</p>	<p>The grounds and gardens are not completed.</p> <p>The bedrooms with ranch sliders and the exit doors to the outside are not ramped to allow safe exit and entry to the building.</p>	<p>Ensure the grounds and gardens are completed to allow for residents' safety when outdoors.</p> <p>Ensure the bedrooms with</p>

				<p>ranch sliders and the exit doors to outside areas allow safe exit for residents using walking frames/mobility aids and/or wheelchairs.</p> <p>Prior to occupancy days</p>
<p>Criterion 1.4.3.1</p> <p>There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.</p>	PA Low	<p>There are adequate numbers of accessible toilet and shower areas throughout both the new build and the existing building. Maintenance is required in two of the areas in the existing building.</p>	<p>One toilet hand wash dispenser is broken in the resident toilet area, and one bathroom wall lining is badly damaged with the surface scratched down to the chipboard backing which does not allow good infection control cleaning standards to be met.</p>	<p>Ensure all bathroom and toilet areas are maintained to allow good infection control practices to be met.</p> <p>180 days</p>
<p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas for the safe and hygienic storage of</p>	PA Low	<p>The cleaning trolley is securely stored when not in use. Laundry powder is purchased locally and decanted into a container for daily use. The container was not labelled to identify first aid instructions. The box of laundry powder from which the chemicals are decanted is kept in the</p>	<p>Not all chemicals were labelled and material safety data sheets were not available for current chemicals in use.</p>	<p>Ensure all chemicals are correctly labelled and that material safety data</p>

cleaning/laundry equipment and chemicals.		<p>office area which cannot be accessed afterhours by staff.</p> <p>One unlabelled bottle of cleaning chemicals located on the day of audit was disposed of at the time of audit. There were no material safety data sheets for the chemicals used at the facility. These were obtained and placed in the required areas during the audit.</p>		<p>sheets are current for all chemical on site.</p> <p>90 days</p>
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>There is an approved evacuation scheme for the existing building, but it does not include the new building. An updated evacuation plan has been sent to the fire service and the owner/director is waiting for it to be approved.</p>	<p>The current fire service approved evacuation plan does not cover the new build. Staff have yet to undertake a fire drill for the new premises.</p>	<p>Provide evidence that an approved fire service approved evacuation plan is in place covering the new building and that staff have undertaken a fire drill in the new build.</p> <p>Prior to occupancy days</p>
<p>Criterion 3.2.1</p> <p>The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary</p>	PA Moderate	<p>The soap dispenser and paper towel holder in the sluice room were empty. There was no full-face mask to prevent splashes to the face when scrubbing soiled linen. The sluice had running water, but the flush mechanism was not working. Gloves were kept in the cupboard.</p> <p>Interview with the clinical manager confirmed these findings. She reported that a full-face mask had been purchased but this could not be located.</p>	<p>The present sluice room does not provide easy access to adequate hand washing facilities and personal protective clothing to ensure staff, residents and visitors exposure to infectious agents is minimised</p>	<p>Provide evidence that infection control standards are met.</p> <p>30 days</p>

to achieve the requirements of this Standard.				
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## Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
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End of the report.