

Blockhouse Bay Healthcare Limited - Blockhouse Bay Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Blockhouse Bay Healthcare Limited
Premises audited:	Blockhouse Bay Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 August 2020 End date: 11 August 2020
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	52

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

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

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff and a general practitioner.

The previous certification and partial provisional audit resulted in 12 corrective actions. These related to the fire evacuation scheme, the completion of the internal environment, external physical environment, building plant and equipment, the appointment of appropriate service providers, medication management, 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. All corrective actions have been addressed but there is one corrective action that remains partly open and is related to equipment in the sluice area. This audit identified a further two areas requiring improvement relating to business planning and medication management.

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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At Blockhouse Bay Home, open communication between staff, residents and families is promoted. There was access to interpreting services when required. Staff provided residents and families with the information they need to make informed choices and give consent.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Policies and procedures support service delivery and were current and reviewed regularly. Monitoring of the services provided to the governing body was 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.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The multidisciplinary team, including a registered nurse (RN) and general practitioner (GP), assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

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

Medicines are administered by staff who are competent to do so.

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		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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There was a current building warrant of fitness. The facility has policies to ensure that maintenance is undertaken and legislative requirements are met.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Nine restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Environmental restraint, being a number code lock on the front door of the rest home for safety reasons, is well managed.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme for Blockhouse Bay Home is led by an experienced and trained infection control coordinator. The environment is managed in a way that minimises the risk of infection to residents, staff, and visitors. The infection control coordinator is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. Specialist infection prevention and control advice is accessed when needed. Staff demonstrated good principles and practice around infection control on the day of the audit.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. There have been no infection outbreaks reported since the last audit.

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	19	0	1	2	0	0
Criteria	0	49	0	1	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that four complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans 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>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code.</p> <p>Blockhouse Bay Home has 12 residents that do not speak or understand English. There are staff on each shift that can interpret if required. Staff are also supported by an interpreting phone app and language cards and</p>

conducive to effective communication.		knew how to access interpreter services. Staff also support a resident who is only able to communicate via body language and facial expressions. Residents and families interviewed reported that the staff at the facility communicate appropriately.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	PA Low	<p>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 monthly reports to the board of directors/owners showed adequate information to monitor performance is reported including financial performance, emerging risks and issues. There is no strategic and business plan for 2020 and not all internal audits to date had been completed.</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>On the days of audit there were 52 residents and one boarder. Two residents (one resident at rest home level and one resident at hospital level care) were receiving services under a Taikura Trust contract. One resident was under a Primary Options for Acute Care (POAC) contract and 49 residents were receiving care under the ADHB Age Related Residential Care contract.</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 facility 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, and clinical incidents including infections.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting/quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities (refer to criterion 1.2.1.1). Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed that the residents/families and staff were overall happy with no 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 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</p>

		development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
<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 management team and at staff meetings.</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 since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Two health care assistants (HCAs) are completing level four, three HCAs have completed level three and one has commenced level three. There are two HCAs that have commenced level two and newly employed HCAs are to be enrolled.</p> <p>The previous audit identified an area for improvement to ensure that the service provides registered nurse cover across the 24 hours, seven days a week period. The corrective action is now addressed. Records demonstrated that there were sufficient trained and competent registered nurses supporting the RN Manager. Currently two registered staff are interRAI trained and one RN is booked to complete training. The RN manager stated that a further two newly appointed RNs will also be booked for interRAI training once their orientation has been completed. Annual competencies for interRAI were sighted. Records also reviewed demonstrated completion of the required training, and completion of annual performance appraisals.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>The previous audit identified an area for improvement to ensure that all shifts are covered appropriately to ensure resident care is delivered safely and that all staff have a rostered day off. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. A cleaner is rostered seven days a week from eight hours a day. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. The RN manager is available on call after hours.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs check medications against the prescription. Clinical pharmacist input is provided six monthly and on request. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>There was adequate and suitable place for the storage of medicines and adequate medication trolleys.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines. The required three-monthly GP reviews were consistently recorded on the electronic medicine charts.</p> <p>There were no 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, when required.</p> <p>The previous area for improvement regarding a plan for a safe medication management system to accommodate many residents in the new unit has been addressed.</p> <p>Expired pro re nata (PRN) medication was found in the stock in use and three of these were administered to</p>

		residents past the expiry dates.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Residents' dietary needs were assessed on admission and dietary profiles were developed. The personal food preferences, special diets, allergies and modified food textures were documented and made known to the kitchen staff. Copies of dietary profiles were sighted in the kitchen records reviewed.</p> <p>The food service is provided on site by two cooks and one kitchen assistant and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. The cooks have completed safe food handling qualifications, with kitchen assistants completing relevant food handling training.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The food control plan was registered with Auckland City Council and was current. Food and fridge temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan.</p> <p>Special equipment, to meet residents' nutritional needs, was available. The kitchen and the pantry were clean on the day of the audit. Records of cleaning schedules were in place in the documents reviewed.</p> <p>Evidence of resident satisfaction with meals was verified by residents and family interviews, satisfaction surveys and resident' meetings minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as, continence, mobility, pain scale, falls risk, skin integrity, nutritional screening, and as a means to identify any deficits and to inform care planning. The reviewed care plans had an integrated range of resident-related information. The reviewed residents' records had current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. The interRAI assessments reviewed were consistent with the needs of the residents. The previous area requiring improvement has been addressed. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused,</p>	FA	<p>The reviewed care plans reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. The previous area of improvement regarding lack of consistency and full description of the support the residents require to achieve their desired outcomes in the care plans was</p>

integrated, and promote continuity of service delivery.		<p>addressed.</p> <p>The care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required 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>	FA	<p>Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is promptly implemented. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy (DT), and an activities assistant. A social history and assessment is undertaken within the first week of admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments were regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs were evaluated regularly by the DT as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. A variety of activities offered include exercises, newspaper reading, walks, board games, church services, music and van outings. The activities are combined for rest home and hospital level residents. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Interviewed residents confirmed they find the programme satisfactory.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. Any changes noted were reported to the RN. Formal care plan evaluations were completed every six months following the six-monthly interRAI reassessments, or as residents' needs changed. Where progress was different from expected, the service responded by initiating changes to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated. Short-term care plans for urinary infections, wounds and post-surgery treatment were sighted. Unresolved problems were added on to long term care plans. Residents and</p>

comprehensive and timely manner.		families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Moderate	<p>Appropriate policies are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment. The previous audit identified several areas for improvement to ensure that the new building has a current code of compliance, to ensure the physical environment is completed to promote safe mobility and aid independence, to ensure that all call bells are active, to ensure that hot water temperatures are appropriate, to ensure that the grounds and gardens work is completed and to ensure the bedrooms with ranch sliders and the exit doors to outside areas allow safe exit for residents using walking frames/mobility aids and/or wheelchairs. The corrective actions have been partly addressed but further improvements are required in the sluice areas.</p> <p>A current building warrant of fitness (expiry date 24 June 2020) was publicly displayed. Appropriate systems/furnishings internally and externally are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. There was evidence of monthly call bell audits ensuring that all call bells are active including hot water testing. The lift for the hospital is operational. The kitchen extension has been completed. The hospital floor upstairs dining room has access to the kitchen via a dumb waiter. The laundry has adequate equipment to cater for the residents. The environment was hazard free and residents' safety was promoted.</p> <p>The facility has access to two working sluice rooms. The upstairs hospital sluice has a sluice and washing machine. Downstairs in the rest home there is access to a sluice room adjacent to the laundry. In interviews with staff it was identified that they are not using the upstairs hospital sluice but bringing all soiled garments and equipment that requires cleaning down to the rest home sluice. The staff do not have access to a sanitiser and are rinsing the equipment with hot water and then returning it to the resident. The staff interviewed stated that equipment is not shared between residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The previous audit identified an area for improvement to ensure that all bathroom and toilet areas are maintained to allow good infection control practices to be met. The corrective action is now addressed as reviewed in records and from observation. All areas have a hand basin. Six hospital rooms have a toilet and no shower. One room does not have a toilet or shower. All remaining hospital rooms have a shower and toilet. The rest home has three common area showers. A toilet and hand basin are shared between each two bedrooms. Appropriately secured</p>

facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site by care staff. Care staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. These staff undertake the New Zealand Qualifications Authority Certificate in Cleaning (Level 2), as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. There was evidence of a cleaning audit having been completed but no laundry audit (see criterion 1.2.1.1).</p> <p>The previous audit identified an area for improvement to ensure that all chemicals are correctly labelled and that material safety data sheets are current for all chemicals on site. The corrective action is now addressed with records available to demonstrate this information in both the laundry and sluice room.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The previous audit identified an area for improvement to ensure that an approved fire service evacuation plan is in place covering the new building and that staff have undertaken a fire drill in the new building. The corrective action is now addressed, and records were available to demonstrate this. The current fire evacuation plan was approved by the New Zealand Fire Service on the 31 July 2019. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 12 March 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the National Emergency Management Agency recommendations for the region.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and</p>

		<p>residents and families reported staff respond promptly to call bells. There are close circuit cameras located in common areas of the hospital the exit doors and in the car park. These are monitored from the nurses' station and the owner/directors cell phone. The owner/director stated that cameras are due to be put into the rest home area this coming week and further signs will be put up throughout the facility. The owner/director also stated that information about the cameras will also be added to all residents admission agreements.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator (ICC) has appropriate skills, knowledge and qualifications for the role. She has attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the district health board (DHB), the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. The previous area of improvement regarding adequate hand washing facilities and personal protective clothing to ensure protection and minimisation of exposure to infectious agents to staff, residents and visitors has been addressed. Refer also to 1.4.2.4</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 and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, and the upper and lower respiratory tract. Infections were recorded on the infection report forms. The ICC reviews all reported infections, and these are documented. Interviewed staff reported that new infections and any required management plans are discussed at handover, to ensure early intervention occurs. Interventions were acted upon and evaluated in a timely manner.</p> <p>The ICC collects monthly surveillance data and analyses it to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year and comparisons against previous months and this is reported to the nurse manager.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is</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 her role and responsibilities.</p>

actively minimised.		On the day of audit, nine residents were using restraints. No residents were using enablers. A similar process is followed for the use of enablers as is used for restraints.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Low	Staff interviewed reported that they are updated regularly in meetings about new policies and procedures, health and safety issues, incidents and changes in service delivery. That any concerns they raise are addressed. The strategic and business plans for 2018 and 2019 were sighted. The RN manager was able to verbalise the strategic and business plan for 2020 but there was no documented plan. There was evidence of an internal audit schedule, however four of the planned 20 internal audits to date for 2020 had been completed. The RN manager stated that once the two new registered staff are orientated the audits will be delegated out to staff to complete.	There is no strategic and business plan for 2020. Not all planned internal audits have been completed.	Ensure that there is strategic and business plan for 2020 and internal audits are completed to reflect the 2020 audit schedule. 180 days

<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>	<p>PA Moderate</p>	<p>Twelve residents' electronic medication records were reviewed. All records had PRN medicines prescribed. PRN pre-packaged medications were stored safely in locked cupboards in the nurses' station. The staff reported that there is a process in place to return expired and unwanted medications back to the pharmacy. Records of returned medications were kept on site and these were sighted in the records reviewed. There was expired PRN medication in the medication storage cupboard.</p>	<p>Ten expired PRN medications were sighted in the medication storage cupboard in the nurses' station. Three of the ten expired medications had been administered to residents.</p>	<p>Ensure that all guidelines and best practice for medication administration and disposal is evidenced.</p> <p>30 days</p>
<p>Criterion 1.4.2.4</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>PA Moderate</p>	<p>The facility has two working sluice rooms. The upstairs hospital sluice has a sluice and washing machine. Downstairs in the rest home there is access to a sluice room adjacent to the laundry and sighted also was hand washing facilities and personal protective clothing. In interviews with staff it was identified that they are not using the upstairs hospital sluice but bringing all soiled garments and equipment that requires cleaning down to the rest home sluice. The staff do not have access to a sanitiser and are rinsing the equipment with hot water and then returning it to the resident.</p>	<p>Staff working upstairs in the hospital are not using the sluice and do not have access to a sanitizer. The rest home sluice does not have a sanitiser.</p>	<p>Provide evidence that staff have access to appropriate equipment in both sluice areas and to also meet infection control standards.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.