

APPQ Limited- Torbay Rest Home

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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:	APPQ Limited
Premises audited:	Torbay Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 18 June 2019 End date: 19 June 2019
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	37

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

Torbay Rest Home provides rest home and dementia levels of care for up to 52 residents. During the audit there were 37 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures and other documentation; a review of residents and staff files; observations and interviews with family members, staff, management and a general practitioner.

The nurse manager and a clinical nurse leader were on site during the week. The residents and relatives spoke positively about the care and supports provided at the rest home.

Improvements identified at the audit are required to the following: annual completion of performance appraisals and the activities programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The systems protect their physical privacy and promote their independence. There is a documented Māori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained.

Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these. Each resident in the dementia unit has an Enduring Power of Attorney.

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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Operational management is delegated by the owner to the clinical nurse manager with support from the clinical nurse leader and the administrator.

There is a documented quality and risk management system in place that includes quality and risk management plans. There are a range of policies, procedures and forms in use to guide practice. Key components of the quality management system include analysis of data around risks, complaints, incidents, accidents and results from review of goals and surveys. The organisational meetings include discussion around data.

The human resource management system is documented in policy with recruitment completed as per policy. There is an implemented orientation and induction programme and an annual training plan implemented. Staff in the dementia unit are trained to provide specific care and support for the residents. There is a documented rationale for determining staff levels and staff mix to provide safe service delivery and there are adequate numbers of staff to meet acuity and numbers of residents. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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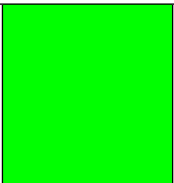
There is an admission package available prior to or on entry to the service. A registered nurse is responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three monthly by the GP.

The activities coordinator implements the activity programme. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.


All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents and families commented positively on the meals. Snacks are always available.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are twelve superior units with ensuites. All other rooms have toilets and hand-basins but share communal showers. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. Systems and supplies are in place for essential, emergency and security services.

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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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents using restraints or enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse has attended external education and coordinates education and training for staff. Infection prevention and control is integrated into full staff meetings. There is a suite of infection control policies and guidelines to support practice. A monthly infection control report is completed for analysis.

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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with three managers (the owner, nurse manager, clinical nurse leader), and ten staff (one administrator, four caregivers, one activities coordinator, one cook, one cleaner, one laundry staff, and one maintenance staff) confirmed their familiarity with the Code relative to their roles and responsibilities. Interviews with eight rest home residents and five family members (three dementia, two rest home) confirmed that the services being provided are in line with the Code. Aspects of the Code were discussed at resident and staff meetings held to date, as confirmed in a review of meeting minutes.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has in place a policy for informed consent. Completed general and resuscitation consent forms were evident on all resident files reviewed (five rest home and two dementia). Discussions with staff confirmed that they were familiar with the requirements to obtain informed consent for entering rooms and personal care. Enduring power of attorney (EPOA) evidence is filed in the residents' charts. In the dementia unit all residents sampled had activated EPOAs.</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>	<p>FA</p>	<p>A policy describes access to advocacy services. Staff received training on advocacy from a Health and Disability Advocacy Service staff member. Information about accessing advocacy services information was available in the entrance foyer and on the complaint's forms. This included advocacy contact details. The information pack provided to residents at the time of entry to the service also provided residents and family with advocacy information. Support is available if requested with family all stating that they knew how to contact an advocate if required. Interviews with staff, residents and relatives confirmed they were aware of advocacy services and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. Residents and relatives confirmed this and provided examples of a variety of community functions and groups they attend. Visiting can occur at any time.</p> <p>There are no set visiting hours and family are encouraged to visit as confirmed by family interviewed. Family members were observed to engage with residents during the day of audit. Residents are supported and encouraged to partake in the planned activities programme as per their care plan (link 1.3.7.1). This was confirmed in residents' records sampled.</p> <p>Discussions with family identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident's family and chosen social networks.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. There are complaint forms available at the entrance to the facility. Information about complaints is provided on admission. The nurse manager and the clinical nurse leader operate an 'open door' policy. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. The complaints for 2018 since the change in ownership and for 2019 were reviewed. There have been two complaints received. One was resolved the day after receiving this and the second was received on the day of audit and is being investigated. Documentation included follow-up communication and confirmation that the complainant was satisfied with the outcome. The complaint was managed in accordance with guidelines set by the HDC.</p> <p>Complaints received are linked to staff meetings. Discussions with residents and relatives</p>

		confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Posters display the Code and leaflets are available at reception. On entry to the service, the nurse manager, the nurse leader or the administrator discuss aspects of the Code with the resident and the family. The service can provide information about the Code in different languages and/or in large print if requested. Written information is given to residents and/or next of kin/enduring power of attorney (EPOA) to read with the resident and discuss.</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>The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed to respect residents' privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met and their privacy maintained.</p> <p>A policy describes spiritual care. All residents and family interviewed indicated that each resident's spiritual needs are being met. Residents were supported to attend their own churches if they desired and church services were held in the service. Notices on the noticeboard advertise communion and other church services held weekly.</p> <p>Staff received training around resident abuse and neglect. There were no reported instances of either in incident forms reviewed since the change in ownership in 2019. Staff, residents and family were asked if there was any sign of abuse or neglect and all stated that there was never any abuse or neglect at the service.</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>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan documented for the service. Activities included Māori entertainers. Staff training included cultural safety with this offered annually. Discussions with care staff confirmed that they were aware of the need to respond to cultural differences.</p> <p>Two residents identified as Māori. A Māori assessment and plan had been completed for both residents that included key contacts, a whānau focus and iwi. The care plan also included any specific requests for care from a cultural perspective. Care plans included input from the resident and their whānau. One resident interviewed who identified as Māori stated that their cultural needs were met.</p> <p>The service can access Māori advisors through the Waitemata District Health Board and has in the</p>

		past accessed the service for tikanga such as blessing rooms after a death of a resident.
<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>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that their cultural and individual values were being met, and these were documented in care plans sampled.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has implemented a code of conduct. The nurse manager supervises staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p> <p>Staff demonstrated care and compassion towards the residents as observed during the audit. Residents and families interviewed stated that the care provided was 'excellent'. Families and residents interviewed stated there is no evidence that staff breach any professional boundaries. Previous and current training plans sampled confirmed there is ongoing education regarding discrimination as part of the training around resident rights.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Policies and procedures guide staff actions with these linked to evidence-based practice. These align with the Health and Disability Services Standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external consultant. The nurse manager, administrator and the clinical nurse leader have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice. Access was able to be described by the nurse manager.</p> <p>Staffing was provided to meet resident needs. There is a general practitioner who visits the facility at least weekly and as required. The general practitioner stated that they were confident in the skills and abilities of the nurse manager and clinical nurse leader to provide clinical leadership and oversight.</p> <p>Family members and residents interviewed confirmed they were very satisfied with the care provided.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Family, including family for residents in the dementia unit, confirmed that they and their family member were welcomed into the unit with communication around the model of service provided and support given to their family member to adjust to the unit. The welcome pack has a specific section around the dementia unit.</p> <p>Accident/incidents, complaints procedures and the policy and process around open disclosure alerted staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incident/accident forms were viewed. The forms included a section to record family notification. Family notification is also documented in the residents' progress notes.</p> <p>A consent form identified situations that family wished to be contacted with this completed in each resident record reviewed. All incident/accident forms reviewed confirmed family were informed following an adverse event if they indicated that they wanted to be informed. Family interviewed confirmed they are kept informed of any changes in their family member's health status.</p> <p>Interpreter services are available if required. Family and staff were used in the first instance. There was one resident who had English as a second language, but they were also fluent in English. Family were used as interpreters and the family member interviewed stated that staff always rang them if they needed an interpreter.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Torbay Rest Home provides rest home and dementia levels of care for up to 52 residents. This includes ten dementia beds (seven occupied on the day of audit) and 42 beds identified as rest home level of care including 12 superior units and one double room occupied by a single resident. On the day of the audit, there were 29 rest home level residents including nine in the superior units and one resident in a superior unit who receives care under an assisted living contract. All other residents were on the age-related residential care services agreement (ARCC) contract.</p> <p>The owner is on site daily during the week to monitor service delivery and to communicate with the nurse manager. The owner also owns two rest home level facilities in Auckland.</p> <p>The organisation has established business goals and a quality and risk management plan. The nurse manager was appointed to the role in April 2019 and has a background in management roles prior to this for five years. They provide operational management and clinical oversight. The nurse manager has completed a minimum of eight hours of professional development over the past 12 months relating to the management of an aged care facility. They are supported by the clinical</p>

		nurse leader who is also employed five days a week.
<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>In the absence of the nurse manager, the clinical nurse leader is in charge with support from the owner if required. The administrator also provides support for administrative tasks. The clinical nurse leader has been in the role since April 2019 and has previous experience in aged care.</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>A quality and risk management programme is in place. Interviews with care staff confirmed their understanding of the quality and risk management systems that have been put into place. Policies and procedures are provided by an external consultant and include interRAI procedures. A system of document control is in place with evidence of regular reviews. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes.</p> <p>Quality goals are documented. The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents, resident satisfaction and infection rates. Adverse events are also trended individually by resident. Internal audits regularly monitor compliance. A corrective action form is completed where areas are identified for improvement with evidence of resolution of issues. Staff are kept informed of results and any corrective actions through staff meetings and staff handovers. The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. Annual resident satisfaction surveys are completed. The last resident and family satisfaction survey results completed in July 2018 have been correlated and no corrective actions were required. The satisfaction survey results indicated a high level of satisfaction with the service.</p> <p>A health and safety programme is in place, which includes managing identified hazards. The nurse manager oversees the programme. There are two health and safety representatives (maintenance staff and administrator). Health and safety training begins during the new employee's orientation and continues in the annual training programme. The topic of health and safety is discussed each month in the staff meetings. The hazard register is regularly reviewed and updated as new hazards are identified.</p> <p>Falls prevention strategies included the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data are collected and analysed monthly and a report is documented and shared at the monthly staff meetings.</p> <p>Fifteen resident related incident forms were reviewed for 2019. The accident/incident forms that were selected for review indicated that immediate action had been taken, including half-hourly neurology observations for any suspected head injury or for an unwitnessed fall. All were signed off by the nurse manager as being completed with actions taken to prevent further incidents documented.</p> <p>Discussion with the nurse manager and clinical nurse leader confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 reports had been sent to the appropriate authorities for a change in nurse manager, notice of a resident who absconded and notification of an outbreak.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resource management policies in place that includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates are kept. Six staff files (one clinical manager, one clinical nurse leader, one activities coordinator, two caregivers, one cook) reviewed, evidenced implementation of the recruitment process, employment contracts and completed orientation. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. The in-service education programme for 2018 has been completed and the education plan for 2019 is currently being implemented. The nurse manager and clinical nurse leader attend external training, which includes sessions provided by the Waitemata District Health Board.</p> <p>The nurse manager was employed in April 2019 and recognised that performance appraisals were due or outdated. An action plan has been put in place to address the issue.</p> <p>The clinical nurse leader is scheduled for interRAI training July 2019. There is a casual registered nurse who is interRAI trained. They can relieve or support the clinical nurse leader if required.</p> <p>Nine staff are currently employed in the dementia unit. Five of the staff that work in the unit have completed the required NZQA standards and three are in the process of completing theirs. One staff member has only recently been employed. There are also three other caregivers who have completed their NZQA dementia training and who are able to relieve or provide support in the unit if required. All care staff have received annual in-service training around challenging behaviours and caring for residents with dementia.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A staffing policy is in place. Enough staff are rostered on to manage the care requirements of the residents. There are two full-time registered nurses (nurse manager and the clinical nurse leader) employed by the service with on-site cover provided Monday to Friday. There is a casual registered nurse available to provide cover when the nurse manager or clinical nurse leader is on leave. There is also a second casual registered nurse available if required. The nurse manager and clinical nurse leader provide 24-hour on-call cover when not available on site.</p> <p>The rest home roster reviewed covers 30 rest home level residents (including one assisted living). There are four caregivers on the morning shift (two eight-hour shifts and two short shifts (7 am to 1 pm and 7 am to 11 am); three on the afternoon shift (two eight-hour shifts and one short shift (4 pm to 9 pm) and two on night shift. Staff allocate residents to staff according to acuity on the day. All staff were able to respond within at least three minutes to any bell rung on the day of audit. The building is configured to enable staff to respond to a resident's needs whenever they require this.</p> <p>Seven residents are living in the dementia unit. One caregiver is rostered on each shift (morning, afternoon and night). Staff are provided with time out of the unit for breaks by staff in the rest home. Staff from the rest home hear and respond to the call bell in the dementia unit to support the caregiver rostered on duty. This was observed to occur promptly on the day of audit.</p> <p>The activities coordinator is employed five days a week from 9.30 am to 2.30 pm. Two cleaners are employed Monday to Friday and one laundry staff works Monday to Friday and Saturday mornings.</p> <p>The nurse manager and staff interviewed confirmed that extra staff could be called in for increased resident requirements with examples given of this occurring. Staff reported that staffing levels and the skill mix are appropriate and safe. Residents and family interviewed advised that they felt there was sufficient staffing.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregivers or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the diversional therapist. Medication charts are in a separate folder and this is appropriate for the service provided.</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>There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has an information pack available for residents/families at entry. The admission agreements reviewed met the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. All long-term admission agreements sighted were signed and dated.</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>Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The facility uses the 'yellow envelope' transfer system. Communication with family is made.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses an electronic and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The RN and senior medication competent caregivers administer medications. All staff have up-to-date medication competencies and there has been medication education in 2018 with this due again this month. The medication fridge temperature was checked daily. Eye drops were dated when opened.</p> <p>Staff sign for the administration of medications electronically. Fourteen medication charts were reviewed. Medications were reviewed at least three monthly by the general practitioner. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has a kitchen manager who works Saturday to Wednesday 7.30 am – 3.30 pm. There is a cook who works the same hours Thursday and Friday. There is a kitchenhand who works 8.00 am – 3.00 pm and another kitchenhand who works 4.30 pm – 6.30 pm. All have current food safety certificates. The kitchen manager oversees the procurement of the food and management of the kitchen.</p> <p>There is a well-equipped kitchen and all meals are cooked on site. Meals are plated in the kitchen,</p>

		<p>have covers placed on them and are then served from trollies. Meals going to rooms on trays also have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review or as changes occur. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals. They particularly commented on the home baking. The dementia unit has ample snacks available.</p> <p>The food control plan was verified on 14 May 2019.</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>The service records the reason for declining service entry to potential residents should this occur and communicates this to the potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</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>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents whose files were sampled. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but are not limited to) nutrition, pain and continence.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and</p>	FA	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans were resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans were in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of</p>

<p>promote continuity of service delivery.</p>		<p>service integration with documented input from a range of specialist care professionals including the dietitian, wound care nurse and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow.</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>When a resident's condition changed, the registered nurse initiated a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. All care plans sampled had interventions documented to meet the needs of the resident. Care plans had been updated as residents' needs changed.</p> <p>Resident falls were reported on accident forms and written in the progress notes. Neurological observations were completed for unwitnessed falls or falls where residents hit their heads. Family were notified.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms were documented, and wound monitoring occurred as planned. There were three minor wounds being treated. There were no pressure injuries on the days of audit.</p> <p>Monitoring forms were in use as applicable including documentation of weight, vital signs, wounds and behaviour.</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>PA Low</p>	<p>There is an activities coordinator who works 24 hours a week. The activities coordinator is currently completing level 3 education and wants to complete the diversional therapy course. There is currently no oversight of the activity's coordinator or the activities programme. On the days of audit, rest home residents were observed going for walks, enjoying pet therapy, playing games and going on a van outing. There were no activities observed in the dementia unit, but some dementia unit residents came out to join the rest home activities. A caregiver was observed giving one-to-one attention in the dementia unit, but this was interrupted when a resident with behaviour that challenges needed attention.</p> <p>There is a weekly rest home programme in large print on noticeboards. Some residents have a copy in their rooms. Residents have the choice of a variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to residents' needs. Those residents who prefer to stay in their room or who need individual attention have one-to-one visits to check if there is anything they need and to have a chat.</p>

		<p>There is an interdenominational church service every second Wednesday and a Catholic priest comes every second week to give communion.</p> <p>There are van outings every Tuesday. Some residents from the dementia unit go out in the van as well. There is pet therapy every second Tuesday and the rest home has a cat. Entertainers visit the facility every Friday. Happy Hour is also held on a Friday. Special events such as birthdays, Easter, Anzac Day, and Queens's birthday are recognised and celebrated. Currently there are no visiting groups such as schools, pre-schools, but the manager, administrator and activities coordinator are currently negotiating for this to occur. Some residents go out to the RSA and two residents attend the local CMA.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan. Resident meetings are held six monthly.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Six care plans reviewed had been evaluated by the registered nurse six monthly or when changes to care had occurred. The other care plan was for a new admission and review as not required to date. Short-term care plans for short-term needs were evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans were in place for each of the residents and these were evaluated six monthly. The multidisciplinary review involves the clinical nurse lead, caregivers, activities coordinator and resident/family if they wish to attend. There were three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</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>	<p>FA</p>	<p>Referral to other health and disability services was evident in the resident files reviewed. The service facilitated access to other medical and non-medical services. Referral documentation was maintained on resident files. There was evidence of where residents had been referred to the mental health services for older people and the dietitian. Discussion with the registered nurses (nurse manager and clinical nurse leader) identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety data sheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons and goggles are available for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires 30 June 2019. There is a maintenance person who works five hours weekly. The maintenance staff also maintains the gardens with a contracted person to mow the lawns. Contractors for plumbing and electrical work are available when required.</p> <p>Electrical equipment had been tested and tagged. Medical equipment had been calibrated. There were stand-on scales. Hot water temperatures had been monitored randomly in resident areas and were within the acceptable range. The rest home communal lounges and bedrooms were carpeted, and hallways had vinyl. The dementia communal lounge and hallway was carpeted but the bedrooms had vinyl on the floors.</p> <p>Corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is a large safely fenced outdoor area with raised flower beds for the dementia unit. All outdoor areas have seating and shade. There was safe access to all communal areas.</p> <p>Staff interviewed stated they have adequate equipment to safely deliver care for rest home and dementia level of care residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene</p>	<p>FA</p>	<p>The twelve superior rooms in the rest home have ensuites. All other rooms in the rest home have toilets and hand-basins but share communal showers. All rooms in the dementia unit have toilets and hand basins but share communal showers. There are sufficient communal showers. Fixtures, fittings and flooring are appropriate. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs. There are signs on all shower doors.</p>

requirements.		
<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>There are twelve superior rooms in the rest home, and these have lounges/kitchenettes, a bedroom and an ensuite. These are accessible to residents and staff by a covered walkway and ranch sliders. Staff can obtain keys to open the ranch sliders when required. There are 29 single rooms in the rest home and one double. The double room is currently occupied by one person. The facility is currently erecting a rail so that if the room is used as a double, privacy curtains would be able to be put up. Consent has been given to use as a double room if required. There is sufficient space in all areas to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</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>The lounges/dining areas are large. There are small nooks where residents who prefer quieter activities or visitors may sit. Activities occur in the larger areas.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done on site. There is a laundry worker employed for four days a week. When the laundry worker is not on duty a cleaner takes over the laundry work once the cleaning has been completed. The laundry is divided into a "dirty" and "clean" area. There is a laundry and cleaning manual and safety data sheets. Personal protective equipment is available. Cleaning and laundry services are monitored through the internal auditing system. The cleaner's equipment was attended at all times or locked away. All chemicals on the cleaners' trolley were labelled. There is no sluice room but there is a sink in the laundry for the disposal of soiled water and the sluicing of soiled linen if required. The laundry is kept locked when not in use. All chemicals are kept in a locked cupboard.</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>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted with the last drill taking place on 11 July 2018. A contracted service provides checking of all facility equipment including fire equipment.</p>

		<p>Fire training and security situations are part of the orientation of new staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. There is short-term back-up power for emergency lighting.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available across 24/7.</p> <p>There were call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity to their bed and in the toilets. Residents who are at risk of falling or who are unable to activate the call system next to their bed also wear a watch alarm that is activated either manually or if they fall.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is one outdoor area where residents smoke. All other areas are smoke free.</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>Torbay Rest Home has an established infection control (IC) programme that is appropriate for the size, complexity and degree of risk associated with the service. The clinical nurse leader is the designated infection control nurse and responsibilities for the role are described in the job description. Infection control data is discussed at the staff meetings. Infection control education has been provided for staff. The infection control programme has been reviewed in the past 12 months.</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>There are adequate resources to implement the infection control programme at Torbay Rest Home. The infection control nurse has completed education in infection control in the past 12 months. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, and training and education of staff. The policies are reviewed and updated at least annually.</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>	<p>FA</p>	<p>The facility is committed to the ongoing education of staff and residents. The infection control coordinator, who has completed training to ensure knowledge of current practice, facilitates education. All infection control training has been documented and a record of attendance has been maintained. Education around infection prevention and control has been provided as part of the annual training plan.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Systems in place are appropriate for the size and complexity of the facility. Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. The infection control programme is linked to the quality management programme. Outcomes and actions are discussed at quality meetings.</p> <p>There has been one outbreak since the previous audit. The general practitioner was involved in managing and monitoring the outbreak. The district health board was notified as was the Ministry of Health. The facility was put into isolation with all staff reminded of the isolation protocols and infection control policies. Cleaning was reviewed and increased. The administrator stated that the Auckland Regional Public Health service was notified (confirmed through email documentation), and they provided advice and support. The report was documented in the March surveillance summary and while brief, did include key aspects of the outbreak.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. The nurse manager is the designated restraint coordinator. Staff interviews, and staff records</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</p> <p>Staff education on restraint minimisation and enablers was last provided in July 2018. There were no residents with restraints or enablers at the time of the audit.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Staff were overdue for annual performance appraisals. The nurse manager (appointed in April 2019) has recognised the issue and has put a corrective action plan in place to address. This is being implemented. Out of the total number of staff, 55% have a current performance appraisal. Of the staff files reviewed, one of six did not have a current performance appraisal. The sample of staff records was increased and of the three reviewed, a further two did not have a current performance appraisal.</p>	<p>Forty-five percent of staff do not have a current performance appraisal as per policy.</p>	<p>Continue to implement the corrective action plan to ensure that all staff have a current performance appraisal.</p> <p>180 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and</p>	PA Low	<p>There was no oversight of the activities programme.</p> <p>There was a planned rest home activities programme and some residents from the dementia unit come out to join in rest home activities and to go</p>	<p>There was no oversight of the activities programme</p>	<p>Ensure that there is oversight of the activities</p>

<p>provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>on van outings. There was no separate planned activities programme in the dementia unit. There were one-to-one activities provided by caregivers in the dementia unit, but these could be interrupted if residents with behaviours that challenge need attention or cares for a resident are required.</p>	<p>in the dementia unit. While there are one-to-one activities provided by caregivers in the dementia unit, there is no structured activities programme provided by the activities staff.</p>	<p>programme in the dementia unit by a suitably qualified person. Provide a structured activities programme for the dementia unit to meet the needs of those in the unit.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.