Teviot Valley Rest Home Limited - Teviot Valley 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:	Teviot Valley Rest Home Limited	
Premises audited:	Teviot Valley Rest Home	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 17 February 2020	End date: 17 February 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: 14

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

Teviot Valley rest home provides care for up to 14 residents at rest home level care. The nurse manager is a registered nurse with management experience and has been in her role since November 2019. The nurse manager is supported by a board of trustees, another registered nurse and very long-standing staff.

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, the review of residents' and staff files, observations and interviews with residents, relatives, staff, the GP and management. Residents, the GP and relatives interviewed praised the service for the support provided.

This audit has identified improvements required in relation to education, care plan evaluations and medication room temperatures.

The service has achieved a continued improvement rating around improving access to the community.

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.

Teviot Valley rest home staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Discussions with relatives identified that they are fully informed of changes in their family members health status. Information about the Code and advocacy services is easily accessible to residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and relatives are aware of the complaints process.

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.

The service has in place a range of policies and procedures to support service delivery that are reviewed every two years. The service has a quality and risk management plan, a business plan and goals for 2020. Teviot Valley rest home has a documented quality and risk management system that reflects the organisation's values, mission and philosophy and provides goals for measurement of achievement against key areas of the business. This includes incidents/accidents, hazards, internal audits, infections, complaints and concerns. Corrective actions are implemented, documented and followed through to compliance. There are implemented health and safety policies that include hazard identification.

There is a documented skill mix policy for determining staffing levels and skill mixes for safe service delivery. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training, and support. All new employees have a comprehensive orientation on file. The annual training plan is in place which exceeds eight hours. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Residents, relatives and staff reported there is sufficient staff on duty to attend to resident cares.

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.

The nurse manager is responsible for the development of care plans with the input of the residents and family/whānau. Residents are assessed prior to entry and there is a comprehensive assessment document completed by the nurse manager. A sample of resident files were reviewed, and it was identified that assessments, interventions reflected the care provided and evaluations were completed at least six monthly. Wound assessment and management information is adequately documented in the care plan.

There are planned activities available for residents to participate in as well as ongoing community involvement. Residents and family/whānau expressed their satisfaction with the programme.

Medication management, policy and procedures in place. Medication rounds sighted during the audit were in line with current legislation.

All meals and baking is prepared on site. Residents are receiving food, fluid and nutrition that meets the recognised standards and guidelines. Any resident with additional requirements/modified diets is receiving these. Residents commented positively around the food services.

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.

The building has a current warrant of fitness. All rooms are single and were personalised. The environment is warm and comfortable. There is adequate room for residents to move freely about the home using mobility aids. Communal areas are spacious and well utilised for group and individual activities. Seating placement encourages social interaction in the dining room and in the lounge areas. Outdoor areas are well maintained, safe and accessible and provide seating and shade for residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely, and the laundry is well equipped. The cleaning service maintains a tidy, clean environment. There is an emergency evacuation plan in place and sufficient civil defence supplies. There is a first aid trained staff member on duty at all times.

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.

A restraint policy is applicable to the service. There are currently no residents using restraint or enablers. There is a restraint risk assessment tool available. Restraint minimisation education was last completed in March 2019.

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.

There are a range of infection control policies and procedures in place to guide staff to maintain good infection control practices. The infection control programme and its content is appropriate for the size and complexity and degree of risk associated with the service. The programme is approved and reviewed annually by the IC coordinator (nurse manager). Staff are informed about IC practises through meetings, training and information posted up on staff noticeboards.
Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	42	0	3	0	0	0
Criteria	1	89	0	3	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with six staff (one registered nurse (RN), two care workers, one cook and one activities coordinator, one maintenance/board member/relative) confirmed their familiarity with the Code. Seven residents and three relatives (including the maintenance/relative) interviewed confirmed the services being provided are in line with the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Five of five resident files sampled had signed admission agreements, written consents signed by the resident or EPOA with 'do not resuscitate' orders signed for separately. Informed consent processes are discussed with residents and families on admission and staff interviewed advised they seek consent when working with residents. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives.

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff have received education and training on the role of advocacy services in September 2019.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service encourages the residents to maintain relationships with their relatives, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in as much as they can safely and desire to do. Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Resident meetings are held three monthly. The service has exceeded the standard in supporting residents to access the community. A canopy has been built at the entrance of the facility and the driveway to the car park has been sealed. Vehicles can now drive to the entrance and residents can get into the vehicles safely and easily.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures have been implemented and residents and their family/whānau are provided with information on admission. There are complaint forms available at the entrance and in the information pack. Complaints information is provided at entry to the service and is readily available to residents in the service. There is a complaints register with follow-up documentation included. There have been no complaints received since the last audit. Staff are aware of the complaints process and to whom they should direct complaints. Residents and relatives interviewed could all describe being aware of the complaints procedure, and feel comfortable discussing complaints and concerns with the nurse manager.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and advocacy pamphlets are located at the main entrance of the service. On admission the nurse manager discusses the information pack with the resident and the family/whānau. This includes the Code, complaints and advocacy information. The nurse manager provides an open-door policy for concerns/complaints. Information is given to the relatives or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code.

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents are encouraged to maintain independence, engage in activities and access community resources. Interactions between staff and residents were respectful. There is an abuse and neglect policy in place and training was last held in 2018. Education on privacy, dignity, informed consent and advocacy was held in September 2019.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	There are current guidelines for the provision of culturally safe care for Māori residents. Two district nurses belong to Ngai Tahu and work from the same building and are able to offer advice and support if required. The service uses the "flip chart" produced by Southern District Health Board for quick reference and guidance. Discussions with staff confirmed that they are aware of the need to respond with appropriate cultural safety. There were no residents identifying as Māori on the day of the audit.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Residents and relatives interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged. Care planning includes consideration of spiritual, psychological and social needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on privacy and personal boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Teviot Valley rest home meets the individualised needs of residents relating to rest home level care. The service shares a building/site with the local medical centre situated in a small community. Staffing policies include pre-employment, the requirement to attend orientation and ongoing in-

		service training. Care workers complete competencies relevant to their practice including all aspects of caregiving and these are updated annually. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The nurse manager is responsible for coordinating the internal audit programme. Staff/quality meetings and residents' meetings are conducted. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the nurse manager.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. The accident/incident forms reviewed (from November 2019), identified relatives are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and relatives are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Teviot Rest Home Ltd (owner/operating company) comprises of a board of four trustees who meet on a monthly basis with the nurse manager. The Teviot Valley Rest Home Incorporated (charitable society) are responsible for governance, operations, fundraising and improvements. Two members of the Teviot Valley Rest home Ltd board are members of the Teviot Valley rest home incorporated board. A report from the nurse manager is discussed at each board meeting. Teviot Valley rest home provides residential services for up to 14 residents requiring rest home level care. On the day of the audit, there were 14 residents. All residents were under the age-related residential care contract. The facility is overseen by an experienced nurse manager(registered nurse), who has been in

		the role since November 2019. The nurse manager has nursing and management experience. The nurse manager is supported by the Board of Trustees and another registered nurse (RN) who works 16 hours a fortnight, and long-standing experienced care workers. The service has a business plan and goals for 2020. The service has a documented quality and risk management system that reflects the organisation's values, mission and philosophy and provides goals for measurement of achievement against key areas of the business. The nurse manager has maintained well over eight hours annually of professional development training including interRAI skills booster and an infection control study day held by the SDHB.
Standard 1.2.2: Service Management 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.	FA	The part time registered nurse and most senior care worker with the support from the PRIME nurse, provide cover for the nurse manager in times of temporary absence.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Teviot Valley is implementing their quality and risk management system. Monthly accident/incident reports, infections and results of internal audits are completed. Quality matters are taken to the monthly combined staff/quality meetings which includes health and safety and infection control. Resident meetings occur three monthly. An internal audit programme is in place that includes aspects of clinical care. Issues arising from internal audits are either resolved at the time or developed into a quality improvement plan. The closure of corrective actions resulting from internal audit programmes was recorded, signed off by the facility manager and signed by staff who were not present at the meeting. Quality/staff and resident meeting minutes include an accurate reflection of the discussion/outcomes of the meetings, including follow up to actions taken as matters arising. Record of monthly risk identification, and quality indicators is maintained and discussed at the monthly meetings and a copy is filed with the completed monthly internal audits. Teviot Valley Rest Home continue to gain feedback and ‘Thank-you’ cards and emails from relatives around the continuous improvement of the driveway and canopy. The annual resident/relative survey has been completed (six responses were returned) which showed overall satisfaction within all areas of the service. In 2019, responses identified residents were either satisfied or very satisfied with the food services activities, care and

		cleanliness of the home. Two negative comments were made around the laundry service, and a corrective action was in place around the areas mentioned. The nurse manager is overall responsible for health and safety which is discussed at the combined quality/staff meetings. Staff interviewed were fluent in describing actions around incident and hazard reporting. A current hazard register is in place and was last reviewed in February 2020. Falls prevention strategies are implemented for individual residents as required.
Standard 1.2.4: Adverse Event Reporting 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.	FA	There is an incident reporting policy to guide staff in their responsibility around open disclosure. Incident/accident forms include a section to record relatives have been notified. Discussions with the nurse manager and registered nurse confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The MOH was notified when there was a change in management in 2019, and there have been no outbreaks since the previous audit. The service collects incident and accident data and reports aggregated figures monthly to the quality/staff meeting. Incident forms are completed by staff, the resident is reviewed by the RN or most senior care worker, and the nurse manager reviews and signs off once all actions have been completed. Ten incident forms reviewed identified registered nurse follow-up. Minutes of the combined quality/staff meetings reflect a discussion of incident statistics and analysis. The care workers interviewed could discuss incident reporting and confirmed data is discussed at the meetings.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files were reviewed (one registered nurse, and four care workers). All had relevant documentation relating to employment, and current appraisals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is an education plan that is being implemented that exceeds eight hours annually, however, not all compulsory sessions have been held over the last two years. The RN has attended a DHB wound care study day. Interviews with the care workers confirmed participation in the Careerforce training programme. A competency programme is in place that includes

		annual medication, manual handling and infection control competencies. A record of completion is maintained and signed. Competency questionnaires were sighted in reviewed files. The nurse manager is interRAI trained. Two senior care workers have level 4 NZQA qualifications and nine care workers have levels 2 and 3 NZQA qualifications.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Teviot Valley Rest Home has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The nurse manager works five days a week and is supported by the registered nurse and a senior care worker who works alternate weekends. The PRIME nurse from the medical centre also provides oversight when a registered nurse is not available and provides on call. One care worker is rostered for the morning (6.45 am to 3.15 pm) and afternoon shifts (3 pm to 11 pm). A care worker works from 5 pm to 8 pm and helps with the tea meal and personal cares. Care workers work a four on four off roster covering all shifts. One care worker is rostered overnight from 11 pm to 7 am. Interviews with the registered nurse, caregivers, residents and relatives confirmed that there are sufficient staff to meet care needs. All staff have a current first aid certificate.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Staff can describe the procedures for maintaining confidentiality of resident records and sign confidentiality statements. Resident records are integrated and support the effective provision of care services. All entries have been dated and signed with designation. Files and relevant care and support information for residents is able to be referenced and retrieved in a timely manner.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	All enquiries come to the nurse manager who records them. The admission agreement is discussed with new residents and families. There is an admission pack provided to new residents and relatives outlining services, the process and entry to the service. The admission agreement outlines the services that are provided as part of the ARC agreement as well as those are that are excluded. There is also information provided at entry which includes examples of how services can be accessed that are not included in the agreement. Relatives

		and residents confirmed there was information provided prior to admission.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has transfer and discharge policies and procedures in place. A transfer/discharge form is completed as part of the process and retained on file. One of the five files reviewed had transfer information which was fully documented and communicated to assist in meeting the needs of the transferring resident. The PRIME nurse assesses residents for emergency transfer when an RN is not available.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are policies and procedures to guide staff on safe medicine management. Medicines are stored in accordance with relevant guidelines and legislation with the medication management policies and procedures complying with legislation and guidelines. The secure treatment room has a medication fridge. Temperature is recorded weekly and temperatures were within acceptable ranges. The medicine room temperature has been recorded, however was not within expected range on the day of the audit. The service has a four weekly blister pack medication management system for the packaging of all tablets. The nurse manager completes medicine reconciliation on resident admission and when new blister packs arrive. Care workers and RNs are responsible for the administration of medications and all staff who administer medication are assessed as competent. Medication charts are written by the GP and there was documented evidence of three-monthly reviews. Ten paper-based medication charts were reviewed. All had allergy status recorded, photo identification, and at least three-monthly reviews by a GP. All 'as required' medications have an 'indication for use'. Expired medication is disposed of as per policy. No residents were self-medicating. Staff administering medications have a current annual medication competency in place.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service	FA	The food control plan is in place expiring in May 2021. There are policies and procedures that include the principles of food safety, ordering, storage, cooking, reheating and food handling. The menu was reviewed by a dietitian in November 2019. All meals and baking is prepared on site by a full time cook and relief cook, both have completed food safety training. All staff have completed training on safe reheating of food last held on October 2019. Temperatures are monitored and recorded daily for the chiller, freezer and food with the

delivery.		equipment being regularly calibrated. Evening meals are served by caregivers. All perishable foods are date labelled and the pantry goods are rotated on delivery and there is sufficient food for at least three days. Chemicals used in the kitchen are stored in a locked kitchen cupboard. All residents are weighed regularly, monthly or more often if required, a new set of scales has just been purchased. Residents with weight loss or low weight are provided with food supplements and the dietitian is involved as required. There was one resident currently using supplements due to unintentional weight loss. The RN completes the dietary requirement forms on admission and provides a copy to the kitchen. Residents are provided with additional or modified foods if required and alternatives can be requested. The dining room is adjacent to the kitchen and the meals are plated directly from the kitchen to the dining room. Residents and family members interviewed were enthusiastic about the presentation, quality and freshness of the meals provided.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	The nurse manager records the reason(s) for declining service entry to potential residents, this would usually be related to unavailability of beds or incorrect service level. If the nurse manager declines entry the decision is communicated to the potential resident, their family/whānau and the referral agency.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team (NASC) prior to admission. An initial nursing assessment is completed within 24 hours of admission. The GP completes a medical admission within two to five working days. InterRAI assessments have been conducted for all residents and meet the required timeframes, this is evidenced in the five resident files reviewed. Assessments are reviewed at least six monthly. The long-term care plans reviewed reflected the outcome of the assessments and goals were identified.
Standard 1.3.5: Planning	FA	All five of the long-term care plans sampled are specific to resident’s needs with clear descriptions of the support required to meet the resident’s goals and needs under a range of

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.		individualised headings. Allied health professionals are available as required to meet the needs of the residents. Residents and their family/whānau were documented as involved in the care planning and review process. There are short-term care plans (STCP) in use for changes in health status including skin tears and wounds. Short-term care plans are reviewed regularly and signed off when resolved.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care plan provides direction for the caregivers, activity coordinator and the RN to work to. The RN reports progress each day as the carers only record exceptions to the care plan. The nurse manager initiates referral to external nursing or allied health services (eg, physiotherapist or dietitian). Any specialist medical referrals are completed by the GP. Any transfer to hospital must be assessed by the PRIME nurse prior to decision to transfer. There was one resident with a skin tear on the day of the audit. The care plan included a wound assessment, management plan and evaluation in place. No residents had pressure injuries. Wound charts of recently healed wounds identified all wounds had an assessment, plan and evaluation which evidenced progression towards healing. Care plans include a continence assessment and a plan is included with specialist continence advice available as required. Adequate continence supplies were sighted. Monitoring charts are available including (but not a complete list) weights, observations and blood sugar monitoring and are completed as per care plan interventions. The nurse manager has refined the weight monitoring chart to identify the percentage of weight loss or gain, this assists in identifying residents with weight loss. At the time of the audit there was one resident who had a medical review and a supplement had been charted by the GP.
Standard 1.3.7: Planned Activities 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.	FA	The activities coordinator works 17.5 hours per week, Monday to Friday with residents. Each resident's care plan has an activities section developed within the care plan and reviewed at each care plan review. The nurse manager completes the initial assessments and the activities coordinator talks to residents about what they are interested in and what is in the plan that might interest them. The activities coordinator uses exception reporting in the progress notes. Evaluations are completed by the nurse manager in consultation with the activity's coordinator, other staff, the resident and family/whānau. Activities are conducted in a spacious large lounge area. The activities coordinator stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions. They are all actively encouraged to maintain their community and family links, this was

		confirmed by family members and residents. Planning occurs for combined six monthly shared events with the other local facilities (in Cromwell and Alexandra), each facility has a turn to host such an event. There is a weekly activities plan that carries over from week to week, this means the programme is flexible and can respond to the needs of the residents. This process was confirmed by staff, residents and family and residents and family find this responsive and positive. Daily resident attendance records are kept for the activities provided. Activities include (but are not limited to) newspaper reading, housie, happy hour, van outings, church services, quizzes, baking, and games. All residents interviewed advised that the activities coordinator was responsive to their requests and met their needs, age, culture and setting of the service and they enjoy what is provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	In all five files reviewed there is a three-monthly review by the GP. Short-term care plans reviewed had been evaluated and closed out or added to the long-term care plan where the problem was ongoing. The five files reviewed included examples where changes in health status had been documented and followed up. However, not all files sighted had evaluations that did not document progression towards goal achievement.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The nurse manager gathers information from all staff and family/whānau and initiates referrals to allied health services such as dietitian or physiotherapist with other specialist referrals are made by the GPs. The nurse manager is new but described how referrals and options for care are discussed with the resident, family/whānau.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during	FA	Staff orientation process includes chemical usage, hazard management and the use of material safety datasheets. Chemical training for staff is due in March 2020. Hazardous chemicals are appropriately stored in secured areas. There are appropriate sharps bins available. There are gloves, eye protection and aprons available in the sluice and laundry. The safe environment and health and safety manuals have policies on waste management procedures.

service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Teviot Valley Rest Home is a spacious, single level building originally built as the Roxburgh Hospital. There is a door that links it to the medical practice. The current building warrant of fitness expires 25 June 2020. Flooring surfaces are made of non-slip materials. There is a spacious and accessible courtyard with seating and appropriate shade. The gardens are well tended and landscaped with pathways and garden beds. Outdoor ramps have handrails. The rooms are fully furnished and personalised to meet resident's needs. There are fixtures and fittings appropriate to meet the needs of the residents. There is adequate equipment available for use with the residents with medical equipment including a sling hoist that has been checked and calibrated in November 2019. Maintenance issues are recorded in the maintenance book and addressed by a volunteer who attends to preventative and reactive maintenance and repairs. Hot water temperatures are checked monthly and are below 45 degrees Celsius. Testing and tagging of electrical equipment is on a schedule and has been completed.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Teviot Valley Rest Home has 14 single resident rooms with a hand basin in each room. Two bedrooms have their own toilet and two rooms have a full shared ensuite, at present this is only accessible to one resident. There are three communal toilets and two showers with appropriately placed handrails and are well signed and identifiable. The communal bathrooms are large enough to ensure that residents who require assistance are managed safely. There is a staff/visitor toilet.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The residents have personalised their own rooms and the rooms are spacious enough to meet the assessed resident needs. Residents have sufficient space to be able to manoeuvre mobility aids around the bed.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe,	FA	There are large dining room and lounge spaces. Activities occur in the dining and lounge areas. The lounge has a lovely view of the gardens and roads. There is a piano that is regularly played (observed on the day) by a volunteer. There is adequate seating and space for both individual

adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		and group activities to occur. If residents do not wish to attend activities, there are other areas of the building with seating available. The dining room has adequate space to store mobility aids while residents are having their meals. The residents interviewed confirmed their enjoyment of the gardens, outdoor and indoor areas.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are policies and procedures in place for the management of laundry and cleaning practices. A part time cleaner is employed to attend to both cleaning and laundry. The laundry has a dirty to clean flow. The chemicals are stored in a locked cleaning cupboard and there are product user charts and chemical safety datasheets for chemicals used in the facility, cleaning manuals and task sheets are present. Cleaning and laundry audits are included in the annual audit schedule. Residents and family/whānau interviewed confirmed the facility is clean and tidy.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency management plans are in place to ensure health, civil defence and other emergencies are covered. Fire and evacuation training have been provided. Fire drills are conducted six monthly, last completed in October 2019. Civil defence resources are available. Appropriate training, information, and equipment for responding to emergencies has been part of the orientation of new staff. There is an emergency management manual, and a fire and evacuation manual. External providers conduct system checks on alarms, sprinklers, and extinguishers. First aid supplies are available. All staff have current first aid certificates. Emergency lighting is provided, a generator is in place to assist with cooking and electricity during an outage. Extra blankets, torches and supplies are available. There is sufficient food in the kitchen to last for three days in an emergency and there are sufficient emergency supplies of stored water available. The emergency plan was activated during the Roxburgh floods in 2019. The residents did not have to be evacuated; staff came in to help. The community provided a large water tank to keep the facility going, and being a small community, members of the community also visited with casseroles and food for the residents. In the event of a prolonged emergency, the community garden (just behind the facility) could be utilised for vegetables. The caregivers interviewed could describe the events of the flood. The emergency plan was followed, and they described the event as being calm and controlled, and felt they were well informed of changes by the manager and the civil defence team. They stated they were well supported by the community,

		off duty staff, and relatives. Call bells were adequately situated in all communal areas. Each bedroom has a call bell in the bedroom and in the bathroom and light up outside each room and on two display panels. Access by visitors and others is limited to the main entrance. Door checks are made by staff on afternoon and night shifts.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All bedrooms have radiators and room temperatures can be individually adjusted, there are opening windows for adequate ventilation. There is a boiler that heats all hallways and living areas and bedrooms are appropriately heated and ventilated. The communal areas have adequate lighting available.
Standard 3.1: Infection control management 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.	FA	Teviot Valley rest home has an established infection control (IC) programme which has been reviewed in January 2020. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The nurse manager is the designated infection control person with support from all staff. Infection control matters are discussed at all quality/staff meetings. Education has been provided for staff in July 2019. A notice is displayed on entry to the facility asking visitors who are unwell not to visit residents.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at Teviot Valley rest home. The infection control (IC) coordinator has maintained her practice by attending external updates through the SDHB. Infection prevention and control is part of staff orientation. The infection control team includes all staff through the quality/staff meeting. External resources and support are available when required. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and	FA	The infection control manual outlines a comprehensive suite of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly.

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The staff orientation programme includes infection control education. The infection control coordinator has completed external updates and provides staff in-service education sessions including hand washing, standard precautions and outbreak management has occurred in July 2019. Education is provided to residents in the course of daily support with all residents interviewed able to describe infection prevention practice that is safe and suitable for the setting.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The nurse manager is the designated infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly summary, and then analysed and reported at the quality/staff meetings. The infection rate remains very low.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are current policies that reflect best practice and meet the restraint minimisation standard around restraints and enablers. The nurse manager is the restraint coordinator for the facility. There were no residents using enablers or restraints on the day of audit. Staff received training in March 2019 around restraint minimisation. Managing challenging behaviours training is planned for February 2020.

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 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Education sessions have been held over the last two years which has exceeded the required eight hours. A range of compulsory education sessions have been held, however, not all sessions have been covered.	Not all compulsory education sessions have been held within two years including; cultural safety, falls prevention, wound and skin integrity, manual handling, and chemical training. Outstanding sessions have been included into the 2020 planner on the day of the audit.	Ensure all compulsory education sessions have been included in the 2020 planner. 180 days
Criterion 1.3.12.1 A medicines management system is implemented to	PA Low	Medications are stored appropriately in accordance to current legislation. Medication charts reviewed had appropriate prescribing, documented administration sheets were completed, charts were	The temperature of the medication room was being monitored, however exceeded 25 degrees for the day of the	Ensure medications are stored below 25

manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		reviewed by the GP three monthly or as required. Medication fridges temperatures were recorded and within range. The medication room temperatures were above the recommended temperature of 25 degrees Celsius. To assist the room to meet the temperature of 25 degrees or below a fan has been running on hot days and the bulb in the extractor fan had been removed. However, this is not effective on particularly hot days and on the day of audit the temperature exceeded 25 degrees.	audit.	degrees Celsius and processes are implemented where it exceeds temperatures. 90 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	In all five files reviewed there is a three-monthly review by the GP. Short-term care plans reviewed had been evaluated and closed out or added to the long-term care plan where the problem was ongoing. The files reviewed included examples where changes in health status had been documented and followed up within expected timeframes, however, not all evaluations documented progression towards goal achievement.	Four of five resident files do not document progression towards goal achievement.	Ensure all evaluations record progress towards the goal. 180 days

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.	CI	Due to the walk up the steep unsealed pathway to the facility carpark, the previous manager identified that more residents were declining offers to go on outings or attending community	The previous nurse manager identified the tremendous benefit a driveway to the door and the ability to load and unload undercover would be. The main concerns were around the safety of the residents walking up the 60-metre sloped gravel driveway, or down to the street below to access transport with no protection from the weather. Relatives were concerned when frail, sick residents had to be wheeled through the medical centre to gain access to the ambulance. In times of bereavement, the body had to be transported up the steep driveway in times of bad weather or darkness. Residents were resistant to going out on trips due to the long walk up the driveway to get to the facility van. Friends of residents found visiting difficult due to the long steep walk to and from the facility. The sealed driveway with loading bay were build which ends just past the entrance to the rest home. A canopy provides shelter and automatic doors provide safe access for residents to the path. Prior to the driveway and canopy being built, low numbers of residents going out on trips and the requests for trips diminished. There were six trips for 18 residents across nine months in 2019. Since the driveway has been opened in October 2019, there have been three facility trips in three months with 26 residents. The board member interviewed, commented on how members of the senior citizen club now can collect residents and transport them to the club meetings and events easily. Relatives interviewed were very

		groups with friends or relatives.	complimentary of the difference it has made, as residents are now suggesting going out for outings and trips, and the driveway and canopy means they can do this in all weathers. The residents interviewed were also positive around the building of the canopy, as it has “tidied up the area”, and has provided another area to sit and enjoy the fresh air. They commented that going out is so much easier and safer now. On the day of the annual ‘Jimmy’s pies lunch” they saw guests from other rest homes from Alexandra and Cromwell and members from the RSA arrive and depart easily, and comments were made around bringing less mobile residents next time. The ambulance service has applauded the project as this now provides direct and quick access to residents for transfers and in times of emergencies for the first time since the facility opened in 2004.

End of the report.