

# APPQ Limited- Torbay Rest Home

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:

<b>Legal entity:</b>	APPQ Limited
<b>Premises audited:</b>	Torbay Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 1 April 2021      End date: 1 April 2021
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	36

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Torbay Rest Home provides rest home and dementia levels of care for up to 52 residents. During the audit there were 36 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff, and a general practitioner.

The service has refurbished parts of the interior with new carpets and curtains.

The two shortfalls identified at the previous audit around annual completion of performance appraisals and the activities programme have been addressed.

This audit did not identify any areas for improvement.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

The team includes managers and along with registered nurses, health care assistants, and support staff.

The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Resident and family meetings are held, and satisfaction is monitored via annual satisfaction surveys.

Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated.

Appropriate employment processes are adhered to. An education and training programme is established. The roster provides sufficient and appropriate staff cover 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.		Standards applicable to this service fully attained.
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The registered nursing staff are responsible for each stage of service provision. The assessments and long-term care plans are developed in consultation with the resident/family/whānau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents' records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

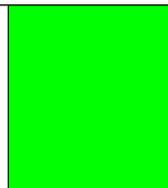
The activity coordinator has developed an activity programme to promote resident independence, involvement, emotional wellbeing, and social interaction appropriate to the level of physical and cognitive abilities of the rest home and dementia care residents.

Medication polices reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. The medication charts reviewed meet prescribing requirements and had been reviewed at least three monthly.

Food services and all meals are prepared on site. Resident's individual food preferences and dislikes are known by kitchen staff and those serving the meals. There is dietitian review of the menu. Choices are available and are provided, with nutritious snacks being available 24 hours per day.

## 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 building warrant of fitness and all external areas were accessible and of an appropriate standard apart from one area of construction which was suitably signposted and cordoned off to ensure resident, staff and visitor safety. There is a preventative and planned maintenance schedule in place. Ongoing maintenance issues are addressed. Chemicals are stored safely on site. Cleaning, laundry, and maintenance staff are providing appropriate services and are well 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.

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.

The infection control coordinator (clinical manager) working together with the registered nurses, is responsible for coordinating and providing education and training for staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There have been no outbreaks.

## 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)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	0	41	0	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.13: 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 assistant manager, the owner/director and the clinical manager described operating an 'open door' policy and confirmed that the facility manager also provided an open door for residents and family. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed including cook, activities coordinator, four health care assistants (HCAs) and one registered nurse were able to describe the process around reporting complaints.</p> <p>There is a complaint register. The complaints for 2020 showed that there had been six complaints with no complaints to date in 2021. Two complaints from the latter part of 2020 were reviewed. Both were resolved the day of or the day after receiving the complaint. 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 confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9:</p>	<p>FA</p>	<p>Six residents in the rest home interviewed stated they were welcomed on entry and given time and explanation</p>

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>about the services and procedures including the model of service in the dementia unit. One family member with family in the dementia unit also stated that they were welcomed, and the complaints process explained to them. There is a complaints policy and procedures. Complaints processes are implemented and managed in line with the Code of Health and Disability Services Consumer Rights (The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code)). Residents and family interviewed verified ongoing involvement with the community.</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 is co-owned by the owners/directors who are on site at least twice a week. The owners/directors also own three other aged care facilities.</p> <p>The service provides rest home and dementia levels of care for up to 52 residents. This includes ten dementia beds (nine 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 27 rest home level residents including nine in the superior units. Two of the rest home residents are using respite level of care. All other residents were on the age-related residential care services agreement (ARCC) contract.</p> <p>One owner/director completes maintenance. The owner/director is on site daily during the week to monitor service delivery and to communicate with the facility manager. The owner director is supported by the facility manager (who provides oversight of two facilities), assistant manager and clinical manager.</p> <p>The organisation has established business goals and a quality and risk management plan. The facility 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 clinical 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 and has been in the service for nine months. They are supported by the assistant manager who has been in the role since September 2020 and who has five years' experience in caregiving.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	<p>FA</p>	<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. 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 monthly staff 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</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>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.</p> <p>Annual resident satisfaction surveys are completed. The last resident and family satisfaction survey results completed in June 2020 have been correlated and no corrective actions were required. The satisfaction survey results indicated a high level of satisfaction with the service. Staff satisfaction is also measured via a survey with all stating that they can voice their concerns. Residents and family meeting minutes (held two to three monthly) evidence tabling of results from the resident and family satisfaction survey.</p> <p>A health and safety programme is in place, which includes managing identified hazards. The clinical manager oversees the programme. There are two health and safety representatives. 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 2020. 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 clinical 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. A Section 31 report had been sent to the appropriate authorities for a change in clinical manager and notice of a resident who absconded.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</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. Five staff files (one clinical manager, one activities coordinator, one registered</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>nurse, two caregivers including one on night shift) 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.</p> <p>The in-service education programme for 2020 has been completed and the education plan for 2021 is currently being implemented. The clinical manager and registered nurse attend external training, which includes sessions provided by the Waitemata District Health Board. Three staff files of the five reviewed included performance appraisals that were current. A further three were reviewed and they too had a current performance appraisal. The shortfall identified at the certification audit has been addressed.</p> <p>Both the clinical manager and registered nurse have completed interRAI training.</p> <p>There are 29 caregivers currently employed in the service and 19 who work in the dementia unit. Sixteen of the staff who work in the unit have completed the required NZQA dementia standards and three are in the process of completing theirs. 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. Staff are rostered on to manage the care requirements of the residents.</p> <p>There are two full-time registered nurses (clinical manager and the registered nurse) employed by the service with on-site cover provided Monday to Friday. Both work 40 hours a week. The clinical manager and registered nurse provide 24-hour on-call cover.</p> <p>There are three caregivers in the rest home in the morning – two are on a long shift and one on a short shift (7AM to 10AM). There are two caregivers in the rest home in the afternoon, both on a long shift, and one two caregivers on overnight.</p> <p>In the dementia unit, there are two caregivers in the morning (one long shift and one shift shift), two in the afternoon (one on shift and one short shift) and one overnight. Staff allocate residents to staff according to acuity on the day. All staff were able to respond within at least three minutes to any call 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. Staff in the dementia unit 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 caregivers 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 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<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 in use. There are no vaccines stored on-site. All clinical staff (RNs, med-comp health care assistants) who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The registered nurse and medication competent health care assistant on duty (interviewed) could describe their role regarding medication administration. The service currently uses robotics for regular medication and 'as required' medications.</p> <p>All medications are checked on delivery against the medication chart (Medimap) and any discrepancies are fed back to the supplying pharmacy. Medications were appropriately stored in the facility medication room. The medication fridge and room temperatures are monitored daily. Temperatures were within acceptable ranges. All eyedrops have been dated on opening.</p> <p>Staff sign for the administration of medications electronically. Ten electronic medication charts were reviewed. The medication charts reviewed identified that the GP had reviewed all resident medication charts three monthly. Each drug chart has a photo identification and allergy status identified. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The meals at Torbay Rest Home are all prepared and cooked on site. The kitchen was observed to be clean, well-organised, well equipped and a current approved food control plan was in evidence. There is a five-weekly seasonal menu that is reviewed by an external registered dietitian. The cook receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, pureed foods) or of any residents with weight loss. The cook (interviewed) is aware of resident likes, dislikes, and special dietary requirements. Alternative meals are offered for those residents with dislikes or religious preferences. Residents have access to nutritious snacks 24 hours a day. On the day of audit, meals were observed to be well presented.</p> <p>Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained appropriately. Staff were observed assisting residents with meals in the dining areas and modified utensils are available for residents to maintain independence with meals. Food services staff have all completed food safety and hygiene courses. There is a food control plan expiring March 2022.</p> <p>The residents interviewed were satisfied with the food service and the variety and choice of meals provided. They can offer feedback on a one-to-one basis, at the resident meetings and through resident surveys.</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>The registered nurse or clinical manager complete care plans for residents. Progress notes in all files reviewed had details which reflected the interventions documented in the long-term care plans. When a resident's condition alters, the registered nurse initiates a review and if required, GP or specialist consultation. Short-term care plans are documented for changes in health status. Staff stated that they notify family members about any changes in their relative's health status, and this was confirmed by family members interviewed, who stated they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Evidence of relative contact for any changes to resident health status was viewed in the resident files sampled. Care plans reviewed documented sufficient detail to guide care staff in the provision of care. A physiotherapist is contracted to assess and assist residents' mobility and transfer needs as required.</p> <p>Wound assessment, appropriate wound management and ongoing evaluations are in place for all wounds. Wound monitoring occurred as planned and is documented on both on a paper based wound log and, in the residents' clinical file. There were five ongoing wounds including three skin tears, and two post-surgical (skin graft) wounds. There were no pressure injuries. The service can access the wound nurse specialist service for advice and input as required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Caregivers stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies, and these were sighted on day of audit.</p> <p>Monitoring charts sighted included (but are not limited to), vital signs, blood glucose, pain, food, and fluid, turning charts, neurological observations, bowel monitoring and behaviour monitoring. All monitoring requirements including neurological observations had been documented as required.</p> <p>Care plans have been updated as residents' needs changed.</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,</p>	<p>FA</p>	<p>There is one activities coordinator who is currently studying to become a qualified diversional therapist. They provide a five-day programme across both care levels and hold a current first aid certificate. The programme is planned monthly and includes themed cultural events, such as Anzac Day, Chinese New Year and Easter. A weekly calendar is displayed in the facility, is available in large print for those residents preferring a paper copy and is read out to sight impaired residents as required. Activities are delivered to meet the cognitive, physical, intellectual, and emotional needs of the residents. One-on-one time is spent with residents who are unable to actively participate in communal activities.</p> <p>A variety of individual and small group activities were observed occurring in both care units at various times throughout the day of audit. Entertainment and outings are scheduled weekly. Community visitors are included in</p>

<p>and the setting of the service.</p>		<p>the programme. Residents are assessed, with family involvement if applicable, and likes, dislikes, and hobbies are discussed.</p> <p>An activity plan is developed, and the resident is encouraged to join in activities that are appropriate and meaningful. A resident attendance list is maintained for activities, entertainment, and outings. Activities include sitting and standing games, quizzes, supported shopping and trips to areas of interest such as 'snow planet'.</p> <p>Resident meetings are held monthly, and family are invited to attend. There is an opportunity to provide feedback on activities at the meetings and six-monthly reviews. Resident and relative surveys also provide feedback on the activity programme. Residents and family members interviewed spoke positively about the activity programme provided.</p> <p>Residents each have an activity assessment and plan including residents in the dementia unit who have a 24-hour plan. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>The dementia unit has its own programme for activities, with the activity's coordinator spending equal time between the rest home and the dementia unit five days a week. The shortfall identified at the certification audit around a dedicated programme for the dementia unit has been met.</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>The organisation's policy requires that care plans are reviewed six monthly or more frequently when clinically indicated. All initial care plans are evaluated by the RN within three weeks of admission. The written evaluations describe progress against the documented goals and needs identified in the care plan. Five long-term care files sampled of permanent residents contained written evaluations completed six monthly. Family are invited to attend review meetings and the GP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes.</p> <p>Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files reviewed. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	<p>FA</p>	<p>The building holds a building warrant of fitness which expires 30 June 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged annually. Items of medical equipment are calibrated annually. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Flooring is safe and appropriate for residential care. All corridors have sufficient room in order to promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>required. The external areas and gardens are well maintained. The dementia unit garden and grounds are safely and securely fenced. The indoor-outdoor flow from the dementia unit allows unrestricted access to the garden area with raised beds and seating area. There is safe access to all communal areas in the facility, including the dementia care unit. All indoor and outdoor areas are fit for purpose and are easily accessible to residents. All outdoor areas have some seating and shade.</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>Infection surveillance is an integral part of the infection control programme and is described in the Torbay Rest Home infection control policy. Effective monitoring is the responsibility of the infection control coordinator (clinical manager). An individual resident infection report is completed for all infections which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used for residents diagnosed with infections as evidenced in the resident files reviewed. Surveillance of all infections is entered onto a monthly infection summary in an electronic spreadsheet, which the infection control coordinator uses to collate the data and analyse any trends arising.</p> <p>The infection control coordinator provides infection control data, trends and relevant information to the facility management and care staff. Areas for improvement are identified, corrective actions developed and followed up. This data is monitored and evaluated monthly. If there is an emergent issue, it is acted upon in a timely manner. On review of the surveillance data the infection rate continues to be very low at the facility and there have been no outbreaks since the last audit.</p> <p>The service has prepared at least two weeks of personal protective equipment including gowns, gloves, and masks. Staff have completed training on use of PPE, cough etiquette and hand hygiene. Residents are provided with training and oversight of standard precautions with this occurring during resident meetings and as required.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. The clinical manager is the designated restraint coordinator. Staff interviews, and staff records 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 2020. There were no residents with restraints or enablers at the time of the audit.</p>

## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.