

# Teviot Valley Rest Home Limited - Teviot Valley 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:

**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: 7 October 2021 End date: 8 October 2021

**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:** 12

# 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
Yellow	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
Red	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. On the day of the audit there were 12 residents. 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, two registered nurses, and a team of experienced staff.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, the GP, and management.

The service has addressed two of the three shortfalls from the previous audit around resident progression towards meeting goals and medication room temperatures. The continues to be a shortfall around education.

This audit has identified shortfalls around the quality system, monitoring charts, and dietitian input.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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A policy on open disclosure is in place. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service. A system for managing complaints is in place.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The nurse manager is responsible for the day-to-day operations. Quality goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. There is a documented education plan which includes competencies. Residents, relatives, and staff reported that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurse is responsible for care plan documentation. InterRAI assessments and care plans are completed within required timeframes. Planned activities are appropriate to the resident's assessed needs and abilities. Residents and families advised satisfaction with the activities programme. The service uses an electronic medication management system. All food and baking is freshly prepared and cooked in the well-appointed kitchen.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Teviot Valley Rest home have been issued with a Form 12 in place of a building warrant of fitness due to Covid lockdowns. Preventative and reactive maintenance occurs. The facility provides easy access to all communal areas, and outdoor areas for residents using mobility aids. The outdoor garden and decked areas are well maintained and provide seating and shade for residents and relatives to enjoy.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Teviot Valley Rest Home continues to be restraint free. There are documented policies and procedures in place should this be required. There were no residents using enablers on the day of the audit.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The service continues to implement their infection surveillance programme. Infection control issues are discussed at the quality/staff meetings. The infection control programme is linked with the quality programme. The recent outbreak was well managed. The service is working towards meeting the recommendations of the Covid-19 preparedness audit. Adequate supplies of personal protective equipment were sighted during the audit.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	12	0	1	3	0	0
<b>Criteria</b>	0	36	0	2	3	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>	FA	<p>Complaints forms are available at the entrance to the facility. Information around the complaints process is provided on admission. The nurse manager reported that a record of all complaints, both verbal and written, is maintained by the manager on the complaints register.</p> <p>There was a complaint sent to the board of trustees from the DHB with recommendations around palliative care, record keeping and communications. This audit identified no concerns around documentation in resident files, and the manager and general practitioner (GP) both described the positive changes around communications with the GP practice. Relatives interviewed were satisfied with the timeliness of communications around changes or incidents, however, there had been no education around palliative cares at the time of the audit. This was arranged with the Hospice on the day of the audit. Documentation and correspondence reflected evidence of responding to the complaints in a timely manner. The nurse manager is currently working towards implementing the recommendations identified. Residents and relatives advised that they are aware of the complaints procedure and how to access forms, and they all felt comfortable discussing concerns with the nurse manager.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers</p>	FA	<p>Comprehensive information is provided at entry to residents and family/whānau. Four residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. The nurse manager and registered nurses are available to residents and relatives and they promote an open-door policy. Incident forms reviewed evidenced that relatives had been notified on all occasions. Two relatives</p>



<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>interviewed advised that they are notified of incidents and when residents' health status changes promptly.</p> <p>The service has access to the interpreter service through Southern District Health Board.</p> <p>The registered nurse, two caregivers, the cook and the diversional therapist interviewed fluently described instances where relatives would be notified. Newsletters are printed four to six weekly and provided to relatives to keep them updated of events and activities around the facility. The relatives interviewed felt communication was maintained throughout the Covid lockdown level when no visiting was permitted.</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>The Teviot Rest Home Ltd (owner/operating company) comprises of a board of four trustees who meet monthly with the nurse manager. The Teviot Valley Rest Home Incorporated (charitable society) are responsible for governance, operations, fundraising and improvements. A report from the nurse manager is discussed at each board meeting.</p> <p>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 12 residents. All residents were under the age-related residential care contract.</p> <p>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 two other registered nurses (RN) who work on a part time basis, however at the time of the audit, one RN was on extended leave, and the other was performing administration duties at the medical centre due to a non-work-related injury. The care staff are long-standing and experienced. The nurse manager also has peer support from a manager of a similar sized aged care facility. The manager was the registered nurse available to the facility at the time of the audit. The district nurses have syringe driver competencies should a resident require one. The PRIME nurse attends to afterhours calls, however, if not available the manager attends to assist the caregivers.</p> <p>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.</p> <p>The nurse manager attends the Central Otago ARC meetings regularly. She has attended education sessions held by New Zealand Aged Care Association and has attended infection control training.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>PA Moderate</p>	<p>The quality plan is in place which includes the values, mission, and philosophy of the service. Objectives for the year include improving the activities programme and focusing on providing a high standard of care for all residents. The combined quality, staff, health and safety and infection control meetings are generally held monthly (when Covid-19 restrictions allow). The meeting minutes are templated to ensure no topic is missed. The minutes of the meetings document in depth discussions held around trending and analysis of infections, and incidents. A range of topics are covered at meetings including (but not limited to), complaints, health and safety, quality goals, staffing,</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>and occupancy. Staff can discuss concerns and provide suggestions at the meetings. There were two resident meetings held in 2020, however there have been no resident meetings held to date in 2021.</p> <p>All current incidents and infections and interventions are discussed at daily handovers between staff.</p> <p>Internal audits have occurred according to the schedule in 2020, however, not all internal audits have been completed according to schedule in 2021, and there was no documented evidence of corrective actions completed to address non-conformities.</p> <p>There was no survey completed in 2020 due to covid19. The 2019 results there was overall satisfaction across the service with a corrective action implemented around resident's knowledge of the complaint process. The 2021 survey evidenced satisfaction around resident's privacy, laundry and cleaning, food services, and the staff. Low satisfaction was identified around activities resulting in a quality goal around improving the activity programme.</p> <p>There are monthly accident/incident and infection reports provided and these were displayed in the staffroom. There is a hazard management, health and safety, and risk management programme in place. The hazard register is reviewed annually, next due in February 2022.</p> <p>Falls prevention strategies are in place according to individual needs; these are documented in the long-term care plan interventions.</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 incident and accident data and reports aggregated figures monthly to the quality/staff meeting. Minutes of the combined quality/staff meetings reflect a discussion of incident statistics and analysis. The caregivers interviewed could discuss incident reporting and confirmed data is discussed at the meetings.</p> <p>Paper-based incident forms are completed by staff, the resident is reviewed by the RN or most senior caregiver, and the nurse manager reviews and signs off once all actions have been completed. Ten incident forms reviewed evidenced registered nurse follow-up or referral to the GP or PRIME nurse after hours service, where appropriate, however, there is no evidence of neurological observations being completed for unwitnessed falls or where the resident has hit their head (link 1.3.6.1). All incident reports were fully completed and documented opportunities to minimise risks (where possible). Relative notification was documented on each report to indicate relatives had been notified.</p> <p>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. There has been no requirement to complete section 31 forms. The recent outbreak was reported to the public health team in a timely manner.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>PA</p>	<p>There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Five staff files were reviewed (one registered nurse, a cook the activity coordinator and two caregivers). All had</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>Moderate</p>	<p>relevant documentation relating to employment, and current appraisals.</p> <p>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.</p> <p>There is an education plan that is documented, however not all compulsory education sessions have been held. This is an ongoing shortfall identified at the previous audit.</p> <p>Interviews with caregivers confirmed participation in the CareerForce training programme. Currently there are six permanent caregivers and two part time caregiver/tea cooks. All caregivers are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications on health and wellbeing through the CareerForce programme. Currently three caregivers have completed level 4, one has completed level 3 and one has completed level 2. A further three (including the activities coordinator) are working towards completing level 2 and one is completing level 3.</p> <p>A competency programme is in place that includes annual medication competency for staff administering medications, manual handling, infection control, first aid and fire safety.</p> <p>The nurse manager and one other registered nurse are trained in interRAI. There is evidence in the registered nurse files of attendance at the DHB external training.</p> <p>The nurse manager, six caregivers and the cook have a current first aid certificate. The activity coordinator is recently employed and will be booked for the next available session.</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>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. The PRIME nurse from the medical centre also provides oversight when a registered nurse is not available and provides on call.</p> <p>One caregiver is rostered for the morning from 6.45 am to 3.15 pm and afternoon shifts from 3 pm to 11 pm and nightshift from 11 pm to 7 am. A caregiver works from 4.30 pm to 7.30 pm and helps with the tea meal and personal cares. An extra caregiver is rostered on weekends from 8 am to 1 pm. Caregivers work four on four off rosters covering all shifts. The activity coordinator works from 8 am to 4 pm covering housekeeping duties.</p> <p>Interviews with the registered nurse, caregivers, residents, and relatives confirmed that there are sufficient staff to meet care needs.</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>Teviot Valley has implemented an electronic medication management system. The supplying pharmacy couriers all medicines in blister packs for regular and 'as required' medications. Medications were checked and signed on arrival from the pharmacy by the nurse manager.</p> <p>Registered nurses and senior caregivers are assessed as medication competent to administer medication. The district nursing service takes care of syringe drivers (when required). Standing orders were not in use. The medication fridge temperatures have been monitored daily and temperatures were within the acceptable range. An air conditioning unit is available to be used when temperatures are close to exceeding 25 degrees. Room temperatures have been recorded daily and have remained below 25 degrees. The previous shortfall around medication room temperatures has been addressed.</p> <p>Ten electronic medication files were reviewed. Medication reviews were completed by the GP three monthly. 'As required' medications were prescribed correctly with indications for use documented. Medications are stored securely. There was one resident who was self-medicating on the day of the audit, who had a competency in place. There were no vaccines stored on site. There were no residents self-administering medications on the day of audit.</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>PA Low</p>	<p>There is a functional centrally located kitchen and all food is cooked on site. There is a food services manual in place to guide staff. There are two cooks who have completed food safety training in July 2021. Food is served from the main kitchen to the dining area adjacent to it. A current food control plan is in place expiring in November 2022.</p> <p>Special diets are being catered for; however, the menu has not been reviewed by a dietitian in the last two years, this was arranged on the day of the audit. Residents have had a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. The cook interviewed was aware of changes in resident's nutritional needs and was knowledgeable around the current nutritional requirements of residents.</p> <p>An annual resident satisfaction survey was completed and showed a high level of satisfaction with food services for the last two years. Regular audits of the kitchen fridge/freezer temperatures and food temperatures were undertaken and documented. All food is stored appropriately. There is special equipment available for residents if required. Residents and relatives interviewed reported satisfaction with food services and baking.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, a registered nurse initiates a review and if required, GP, nurse specialist consultation. The registered nurse and caregivers follow the plan and report progress against the plan each shift. Discussions with relatives confirmed they are notified promptly of any changes to their relative's health. Short term care plans of care are used for short term/acute changes in care. These were in place for wounds and infections in the resident files reviewed.</p> <p>There was one resident with a surgical wound; on the day of the audit, and the district nurses were performing</p>

<p>in order to meet their assessed needs and desired outcomes.</p>		<p>wound cares. There are wound charts which include assessments, plans and evaluations to be completed. Adequate dressing supplies were sighted.</p> <p>Contenance products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Residents are weighed monthly or more frequently if weight is of concern.</p> <p>Monitoring forms were sighted for weight and vital signs, blood sugar levels, pain, challenging behaviour, food, and fluid charts, however, these were not always completed as instructed on care plans.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities coordinator has been in the role for four months. The activities coordinator performs activities in the afternoons across Monday to Friday and is currently working towards completed NZQA level 2.</p> <p>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. Attendance records are maintained. Newsletters are provided to residents and relatives four to six weekly to keep relatives who are not local in touch with what's been happening around the facility, and upcoming events.</p> <p>There is a weekly activity 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. Prior to lockdown, the residents were performing a virtual walk to Alexander, they were walking around the grounds and up to the shops. Distances walked were recorded and mapped on the virtual walk with accompanying photographs of the places the residents had reached. This was paused due to Covid lockdown restrictions. Activities include a wide range of topics, including science experiments, baking, flower arranging, group games, entertainers, and local speakers. The activities coordinator stated at interview that residents are asked frequently to give verbal feedback and asked for suggestions, however, there have been no resident meetings held since March 2020 (link 1.2.3.6). Residents are all actively encouraged to maintain their community and family links, and this was confirmed by relatives and residents interviewed.</p> <p>Celebrations are held around special theme days and resident birthdays. A Samoan cultural day was held, and church services are held regularly. The residents and relatives spoke positively around the range of activities and talked about the science experiments and making banana splits during the audit.</p>
<p>Standard 1.3.8:</p>	<p>FA</p>	<p>All initial care plans for long-term residents were evaluated by the clinical manager or registered nurse within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by the clinical</p>

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>manager or registered nurse six monthly, using the interRAI tool or earlier for any health changes for files reviewed. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes or the care plan. The acute plans of care have been reviewed and evaluated</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service has been issued with a Form 12 in place of the building warrant of fitness. This certificate declares the facility to be safe, however not all checks were able to be completed due to Covid-19 lockdown periods in 2020.</p> <p>A maintenance book is in place and all breakages are currently reported to the nurse manager, who reports this to the maintenance man. There are essential contractors available 24/7. Hot water temperatures have been monitored periodically, however not on a regular basis and there was no documented evidence of corrective actions completed when the temperatures were out of the recommended ranges (link 1.2.3.8). The issues were added to the hazard register during the audit, as there is a long-standing problem with one of the tempering valves. Medical equipment is tagged, tested, and calibrated annually.</p> <p>All areas internally and externally are easily accessible to residents and relatives requiring mobility aids. External areas are well maintained, and seating and shade are provided.</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>Teviot Valley continue to implement their infection surveillance programme. Individual infection forms were completed for all infections. Infections were included on a monthly register and a monthly report and graphs were completed by the infection control coordinator (currently the nurse manager). Infection control (IC) issues were discussed at the combined quality and staff meetings. The IC programme is linked with the quality programme. In-service education is provided annually and in toolbox talks when required. There was one resident who identified as positive for the RSV virus. This was dealt with appropriately, well documented, and then reported appropriately.</p> <p>The service is currently working alongside the infection control nurse specialist for Aged care to meet the recommendations identified at the Covid-19 DHB audit. Improvements since the last audit include the provision of an infection control cupboard where adequate stores of personal protective equipment were sighted, and there were kits made up for staff to access if a resident has an infection and is required to be isolated. Staff interviewed were knowledgeable around isolation precautions. Hospital grade wipes are used to wipe equipment such as the blood glucose monitor between uses. Staff described the use of aprons and gloves and procedures when changing roles from housekeeping to activities for example. Foot pedalled bins have been purchased. Hand gel is freely available throughout the facility. Personal protective equipment including medical grade gloves, aprons, eye goggles and visors were sighted. The service is considering the installation of a sanitiser, and extra storage areas.</p> <p>All visitors are required to ring the door bell and wait to be escorted to their resident by a member of staff. All visitors</p>

		and contractors are required to sign in on entry to the facility for contact tracing purposes, wear masks and use the hand sanitiser provided.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	<p>There is a restraint minimisation and safe practice policy that is applicable to the service. The facility manager is the restraint coordinator. There are currently no residents using restraint or enablers at Teviot Valley.</p> <p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0, however, restraint/enabler and challenging behaviour training has not been provided within the last two years (link 1.2.7.5). Caregivers interviewed could describe the differences between restraint and enablers and procedures around these.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Results of internal audits are discussed at meetings. The 2020 internal audits were completed as scheduled; however, this had not occurred in 2021.</p> <p>Resident meetings were held as per schedule in 2020 but have not been held in 2021.</p>	<p>i) Internal audits have not been completed as scheduled in 2021, including food services, safety, laundry, cleaning, medication, moving and handling/lifting, restraint, challenging behaviour, privacy of information, resident recreation, and code of rights.</p> <p>ii) Resident meetings have not been held since March 2020.</p>	<p>Ensure internal audits and hot water monitoring occur according to schedules.</p> <p>Hold resident meetings as scheduled at regular intervals throughout</p>



				the year.  60 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	There are templated corrective action forms in the internal audit folder, however, there were no documented corrective actions completed for internal audits including hot water recordings which identified non-conformities. Hot water temperatures have not always been recorded as occurring monthly as scheduled.	There was no documented evidence of corrective actions for any non-conformities identified on completion of internal audits or for hot water temperatures recorded when they were outside of the expected ranges.	Ensure corrective actions are documented for all non-conformities identified.  90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	The education plan was completed in 2020 and included extra education sessions held as required around Covid-19. Education sessions have been held in 2021, including elder abuse, food safety, medication management, chemical safety, and continence management. Infection control education has been held with the aged care infection control nurse specialist, however, not all sessions have been held as scheduled.	Education sessions around sexuality and intimacy, resident code of rights, restraint, palliative care, health and safety/hazards, open disclosure and complaints have not been held according to schedule. The risk rating has been increased from low to moderate as the shortfall from the previous audit is not yet closed out.	Ensure all compulsory education sessions occur as scheduled.  60 days
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	PA Low	There are two cooks employed at Teviot Valley, who have had food safety training. Each work on a four on/four off roster. Currently the cooks document all baking, and meals provided to residents, which includes a range of fish and meat, and a range of seasonal vegetables, however, the menu has not been reviewed by a dietitian in the last two years.	The menu has not been reviewed by a dietitian for more than two years.	Ensure the menu is reviewed by a dietitian at least two yearly to evidence nutritional requirements are being met.

				90 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>There is a suite of monitoring charts available for use, however, these were not always completed as instructed in the care plan interventions.</p>	<p>i) Monitoring charts were not completed as instructed by the GP or RN care plan for weekly BP following medication changes.</p> <p>ii) Weekly weights were not recorded for a resident losing weight as care plan interventions instructed.</p> <p>iii) Daily observations were not fully documented as instructed by the short-term care plan for a resident with an infection.</p> <p>iv) There was no evidence of neurological observations completed for five unwitnessed falls, two of which had identified that the resident had hit their head (these residents had been reviewed by the PRIME nurse).</p>	<p>i-iv) Ensure all monitoring charts are completed as per care plan instructions.</p> <p>60 days</p>

## 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.