

# Torbay Rest Home Limited

---

## 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:

<b>Legal entity:</b>	Torbay Rest Home Limited	
<b>Premises audited:</b>	Torbay Rest Home	
<b>Services audited:</b>	Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 9 November 2015	End date: 9 November 2015
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	38	

# 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
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

Torbay rest home provides rest home level care for up to 45 residents. On the day of audit, there were 38 residents.

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

The facility manager (registered nurse) is experienced in the role and supported by a registered nurse who oversees the clinical care. Residents and families interviewed were positive about the care and services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

This audit identified improvements required in relation to open disclosure, completion of corrective actions, hazard management, completion of accident and incident forms, initial GP assessments, care planning, interventions, medication management, food temperature checks, communication of food allergies, hot water temperature monitoring and review of the infection control programme.

## Consumer rights

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

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 complies with the Code of Health and Disability Consumers' Rights. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## 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 quality and risk management programme includes a service philosophy and specific aims for the year. Quality activities are regularly conducted. Meetings are held to discuss quality and risk management processes. Residents' meetings are held and residents and families are surveyed annually. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
--	--	---

The registered nurse is responsible for each stage of service provision. The assessments, initial and long-term nursing care plans are developed in consultation with the resident/family/whānau.

The residents' outcomes/goals have been identified in the long-term care plan and these are reviewed at least six monthly or earlier if there is a change in health status.

The activity programme is developed to promote resident independence and social interaction. Residents interviewed spoke positively about the activity programme.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies.

Food services and meals are prepared on site. There is a dietitian review of the menu. All kitchen staff have been trained in food safety and hygiene.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
--	--	---

The building has a current warrant of fitness. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with hand basins and toilets. There was sufficient space to allow the movement of residents around the facility. The hallways and communal areas were spacious and accessible. The outdoor areas were easily accessible. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site. Hot water temperatures have not been checked in past six months.

Emergency systems are in place in the event of a fire or external disaster.

## 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
--	--	--

The infection prevention and control programme includes policies and procedures to guide staff. Infection prevention and control is integrated into meetings with the health and safety team. The infection prevention and control register is used to document all infections. A monthly infection control report is completed for analysis. The infection and control programme has not been reviewed in the past 12 months. The service has had no outbreaks since the previous 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	34	0	11	0	0	0
<b>Criteria</b>	0	80	0	13	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (two healthcare assistants, one registered nurse (RN), and one manager) confirm their familiarity with the Code. Interviews with all five residents confirmed the services being provided are in line with the Code. Aspects of the Code are discussed at resident and staff meetings.
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	Informed consent and advanced directives were recorded as evidenced in the seven resident files reviewed. Staff advised that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information.

advocacy/support persons of their choice.		Advocate support is available if requested. Interviews with staff, residents and relatives informed they were aware of advocacy and how to access an advocate.
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	Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. On interview, all residents and relatives confirmed this. Visiting can occur at any time.
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. There is a complaints form available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.  There is a complaints register. Complaints for 2014 and 2015 (to date) were reviewed. All complaints have noted investigation, timelines, corrective actions when required and resolutions. One complaint, lodged with the Health and Disability Commissioner (HDC) in 2014 has recently been signed off by HDC. 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.
Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights.	FA	Posters display the Code and leaflets are available at reception. On entry to the service, the RN and the office administrator discuss aspects of the Code with the resident and the family/whānau. The service is able to provide information in different languages and/or in large print if requested. Written information is given to residents and/or next of kin/enduring power of attorney (EPOA) to read with the resident and discuss.
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	The service has policies that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.  A policy describes spiritual care. All residents and family (three) interviewed indicated that each resident's spiritual needs are being met.

		Staff received training around abuse and neglect. There have been no reported instances of either.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Activities include Māori entertainers.</p> <p>Staff training includes cultural safety. One resident identified as Māori. The service is able to access Māori advisors through the Waitemata District Health Board.</p> <p>Discussions with care staff (two healthcare assistants, one registered nurse, and one diversional therapist) confirmed that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that their cultural and individual values were being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has implemented a code of conduct. The manager/RN supervises staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflected high levels of satisfaction with the services that are provided. Residents and relatives interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of the principles of aged care and state that they feel supported by the manager/RN and RN.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>PA Low</p>	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were viewed. The forms include a section to record family notification. Only four of the ten forms indicated family were informed following the adverse event. Two relatives interviewed confirmed they are kept informed of any changes in their family member's health status.</p> <p>Interpreter services are available if required. There were no residents living at the facility who were unable to understand or speak English.</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 owned and operated by an individual who also owns two other facilities in Auckland.</p> <p>The service provides rest home level of care for up to 45 residents, which includes five serviced apartments. There are also seven independent living units on the premises. On the day of the audit, there were 38 rest home level residents. All of the residents were on the Aged-Related Care Contract.</p> <p>The manager is a registered nurse and is on-site on a full-time basis, five days a week. A second registered nurse is employed five days a week, including Saturdays and Sundays.</p> <p>The facility has a business plan, philosophy of care and goals and objectives. Specific aims for the year are documented and are regularly reviewed with the owner.</p> <p>The manager/RN has completed a minimum of eight hours of professional development over the past 12 months relating to the management of an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to</p>	<p>FA</p>	<p>In the absence of the manager/RN, the staff RN and office administrator are in charge. The staff RN qualified in 2013 and has been employed by the service since graduating from nursing school. The office administrator has been employed by the service for 22 years.</p>

consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>A quality and risk management programme is in place. Interviews with the manager and care staff (two healthcare assistants, one registered nurse, one diversional therapist, one cook, one laundry staff, one maintenance staff, and one cleaning staff) reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures are being updated to include reference to InterRAI for an aged care service. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.</p> <p>Data collected (eg, falls, medication errors, wounds, skin tears, challenging behaviours) are collated and analysed with results communicated to staff. An internal audit schedule is being followed. Areas of non-compliance include the initiation of a corrective action plan. There is a lack of evidence to confirm corrective actions are being implemented and signed off by the manager/RN.</p> <p>Falls prevention strategies are implemented specific to the residents. A wireless sensor mat is available. The call bell system is being upgraded to allow sensor mats to be directly linked to the call bell system. The manager has attended a 'Do No Harm' course and plans are in place to purchase alarms for residents to notify staff if they fall outside.</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>	PA Low	<p>There is an accidents and incidents reporting policy. Staff who witness an adverse event are instructed to complete an accident/incident form. Ten 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. Missing on the form is evidence that the registered nurse investigates each accident/incident and that family are always kept informed (link to finding 1.1.9.1).</p> <p>Adverse events are analysed each month and reported back to staff.</p> <p>Discussion with the manager/RN confirmed his awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>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. Seven staff files were reviewed and evidenced that reference checks are completed before employment is offered. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. The in-service education programme for 2014 has been completed and a plan for 2015 is being implemented. The manager/RN and staff RN attend external training, which includes sessions provided by the Waitemata District Health Board. Annual staff appraisals were evident in all staff files reviewed.</p> <p>Both the manager/RN and staff RN have been trained in InterRAI.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A staffing policy is in place. Sufficient staff are rostered on to manage the care requirements of the residents. There are two full-time RNs employed by the service (including the manager) with on-site cover provided seven days a week. An RN is available on call when not available on site. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurse's station. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the diversional therapist. Medication charts are in a separate folder.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services provided, the admission process and entry to the service. All potential residents have a needs assessment completed prior to entry. Seven residents and three relatives confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement aligns with the requirements of the ARRC contract.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the receiving provider. The service ensures appropriate transfer of information occurs. Family/whānau interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>There are policies in place for safe medicine management that meet legislative requirements however the organisational policies were not always followed. On the day of audit, the medications were not all safely stored. Thirteen of 14 medication charts sampled met legislative prescribing requirements.</p> <p>The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. All clinical staff 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. Weekly and six monthly drug checks were documented. The registered nurse and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperatures are recorded regularly and these are within acceptable ranges.</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>	PA Low	<p>The meals at Torbay are all prepared on site. A four weekly seasonal menu is designed and reviewed by a registered dietitian. The cook receives resident dietary information from the RN and is notified of any changes to dietary requirements (vegetarian, moulid foods) or of any residents with weight loss. On the day of audit, the cook (interviewed) was not aware of the information displayed in the kitchen regarding a resident with food allergies and had not been made aware of a resident with special dietary requirements. The cook was aware of resident likes and dislikes. Alternative meals are offered for those residents with dislikes or religious preferences.</p> <p>Food safety management procedures are not always adhered to (link 1.2.3.9). Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and</p>

		<p>modified utensils are available for residents to maintain independence with meals. All food services staff have completed food safety and hygiene courses.</p> <p>The residents interviewed were satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings and through resident surveys.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If the service declines an admission, the decision is communicated to the residents/family/whānau and the potential resident(s) referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>The facility has embedded the InterRAI assessment protocols within its current documentation. The RN and facility manager/RN are competent in the use of InterRAI. All residents have interRAI assessments completed. InterRAI initial assessments and assessment summaries were evident in printed format in the files reviewed. Files reviewed identified that risk assessments had been completed on admission and had been updated at the time of the care plan review. Nursing assessment risk screening tools were not always used for acute changes in care needs (link 1.3.6.1).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>Care plans reviewed were personalised and demonstrated service integration and input from allied health. However not all care plans included specific interventions for all identified care needs (link 1.3.6.1.). Care plans were not always documented to reflect acute changes in health status. Family/whānau members interviewed confirmed the care delivery and support by staff is consistent with their expectations.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	PA Low	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation.</p> <p>Monitoring forms were completed as required and evaluated by the registered nurse. An activities plan is completed on admission and reviewed six monthly with the care plan review.</p>

<p>assessed needs and desired outcomes.</p>		<p>Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP dietitian and specialist involvement in wound care. Not all wounds had documented assessments and evaluations with each dressing change or had wound management plans signed by the RN.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. The registered nurse was able to describe access for wound and continence specialist input as required.</p> <p>The clinical files sampled evidenced involvement of referral to allied health and specialist services as required, including speech language therapist, physiotherapist, dietitian, skin specialist, podiatrist and wound care specialist.</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 diversional therapist works 18 hours per week. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. On the day of audit, residents were observed being actively involved in a variety of activities with support and involvement of the care staff. The programme is developed monthly and displayed in large print. The service receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families. The residents and families interviewed spoke positively about the activities programme.</p> <p>The programme is comprehensive and includes van outings, Zumba, gardening, pet visits, church services, and arts and crafts. There are resources available for staff to use for one on one time with the residents and for group activities.</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>In the resident files reviewed all initial care plans were evaluated by the RN within three weeks of admission. The written evaluations were completed at least six monthly and described progress against the documented goals and the needs identified in the care plan. 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>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	<p>FA</p>	<p>Discussions with the registered nurse and facility manager/RN identified that the service has access to external and specialist providers. The service facilitates access to other medical and non-medical services. The service was able to describe the process they would use if the</p>

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		residents' needs changed and the resident required a different level of care.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are to be stored in locked areas. On the day of audit, all chemicals were stored correctly. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties. Blood and chemical spills kits are available.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Low	<p>The building has a current building warrant of fitness that expires on 30 June 2016. A maintenance staff member works 40 hours per week and a contract gardener who is available on call for facility maintenance matters after hours. Reactive maintenance systems are in place. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have not been tested and recorded in the past six months.</p> <p>Corridors are wide enough in all areas to allow residents to pass each other safely. There is safe access to communal areas and there is outdoor seating and shade (link 1.2.3.9).</p> <p>Staff stated they have all the equipment required to provide the level of care documented in the care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	There are adequate numbers of communal toilets near communal areas. Five resident rooms have en-suites and all other resident rooms have a hand basin and toilet. The communal shower rooms and toilets have occupancy signage and privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares.
Standard 1.4.4: Personal Space/Bed	FA	There is adequate room to safely manoeuvre mobility aids in the resident bedrooms. Residents

<p>Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>and family/whānau are encouraged to personalise their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include open plan lounges and dining areas. There is a separate lounge area and an internal courtyard with seating and shade. The communal areas are easily accessible for residents.</p> <p>Seating and space is arranged to allow both individual and group activities to occur.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and housekeeping staff seven days a week. Cleaning trolleys are kept in designated locked areas (also link 1.2.3.9). Residents and family/whānau interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of the orientation of new staff and includes competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place with a generator available if needed.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation,</p>	FA	<p>Residents are provided with adequate natural light, safe ventilation, and an environment that is</p>

<p>And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>PA Low</p>	<p>Torbay has an established infection control (IC) programme that is appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the designated infection control nurse. Infection control information is discussed at the staff meetings. Infection control audits have been conducted, however corrective actions have not been developed for high infection rates (link 1.2.3.8.). Infection control education has been provided for staff. The infection control programme has not been reviewed in the past 12 months.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Torbay. The infection control (IC) nurse has completed education in infection control in past 12 months. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, and training and education of staff. The policies are reviewed and updated at least annually.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service</p>	<p>FA</p>	<p>The facility is committed to the ongoing education of staff and residents. The infection control coordinator, who has completed training to ensure knowledge of current practice, facilitates education. All infection control training has been documented and a record of attendance has</p>

providers, support staff, and consumers.		been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Education around infection prevention and control has been provided in October 2015.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	Systems in place are appropriate for the size and complexity of the facility. Infection surveillance is an integral part of the infection control programme and is described in CHT's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. The infection control programme is linked with the quality management programme. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. There have been no outbreaks since the previous audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraints or enablers. Staff interviews and staff records evidence 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. Staff education on RMSP/enablers has been provided. Restraint is discussed as part of staff meetings. The manager/registered nurse is the designated restraint coordinator.

## 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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Interviews with relatives confirmed that they are kept informed but this was unable to be consistently evidenced on completed accident/incident forms.	Six of ten incident/accident forms reviewed did not reflect families being informed.	<p>Ensure families are kept informed following accidents/incidents.</p> <p>60 days</p>
<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	Where areas are identified for improvements following internal audits, corrective actions are documented either on a corrective action form or directly on the internal audit form. Evidence is missing to indicate that corrective actions have been implemented and signed off by the manager.	There is a lack of documented evidence to verify that corrective action plans are implemented and signed off.	<p>Ensure there is evidence to verify corrective action plans are implemented and signed off.</p> <p>90 days</p>

<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	<p>PA Low</p>	<p>A risk management plan is in place. Hazards are identified on the hazard register. A hazard identification form is in place for staff to identify any new hazards. There were two hazards identified during the audit that were not actively minimised/isolated/eliminated. Maintenance staff is responsible for completing monthly safety audits.</p>	<p>Hazards identified during the audit included an uneven surface outdoors (noting this was council land); and windows and doors were left open in the kitchen on the first day of the audit, attracting flies. These hazards were included on the register during audit and actions implemented to mitigate risk.</p>	<p>Ensure hazards are documented on a hazard identification form with evidence of each hazard being addressed/mitigated.</p> <p>60 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>The person who witnessed the event completes accident/incident forms. Immediate action is taken and documented on the accident/incident form. The registered nurse is not completing an 'outcome summary' or 'required actions' following the event.</p>	<p>Seven of ten accident/incident forms reviewed were not completed in full. The registered nurse is expected to investigate each event and document an 'outcome summary' and 'required actions' following each event and document this on the form.</p>	<p>Ensure the accident/incident form is completed in its entirety. Areas deemed 'not applicable' should be documented as such.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with</p>	<p>PA Low</p>	<p>Medication management policies and procedures follow current guidelines. The GP prescribes all medication to be administered to the resident on admission and then reviews the medications prescribed at least every</p>	<p>i) One of 14 medication charts reviewed had multiple medications bracketed with a single GP signature. ii) On two separate</p>	<p>i) Ensure that GP prescribing of medication meets legislative requirements. ii) Ensure that</p>

legislation, protocols, and guidelines.		three months. One resident had had multiple medications bracketed with one GP signature. The weekly and six monthly drug checks were completed but did not have a designation next to the signature.	occasions on the days of audit, the medication trolley was found unlocked in an open office area.	medication is stored safely and medication storage meets all legislation and guidelines.  60 days
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Low	The RN provides written information to the kitchen regarding the residents' dietary requirements. On the day of audit, one resident was noted to have celiac disease in the resident file, however this information had not been communicated to the kitchen. The cook was interviewed about residents with known food allergies. The cook had not read the information on display on the wall in the kitchen identifying a resident with known food allergies.	The cook was unaware of the special dietary requirements for: i) One resident with celiac disease, ii) One resident noted to have an allergy to peanuts.	Ensure that information about special dietary requirements and food allergies is communicated and understood by all kitchen staff.  90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Food is stored in accordance with safe food management legislation and guidelines. Food temperatures were not consistently being recorded for food served to the residents. There has been no complaints regarding food temperatures and residents were happy with meals provided.	Food temperate checks are not consistently completed prior to the food being served to the residents.	Ensure that food served to residents is at a temperature that meets current legislation and guidelines.  90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely	PA Low	The initial nursing assessments, initial and long-term care plans and evaluations were completed within the required timeframes. The	Two of seven files reviewed showed that the residents were not seen by the GP within	Ensure that all initial GP assessments are completed within the required timeframes.

meet the needs of the consumer.		documentation of wound care reviews were not all completed in a timely manner (link 1.3.6.1). The GP visits weekly and access to a GP is available afterhours. Not all residents had been seen by a GP within 48 hours of admission to the facility.	48 hours of admission. One resident had the initial assessment documented by the GP 27 days after admission and the second resident's initial GP assessment was documented eight days after admission.	90 days
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	The RN uses information gathered from a multiple range of sources (interviews with the resident and family, the use of monitoring forms, information from the referring agency and InterRAI) to develop the care plan. Nursing assessment tools (eg, behaviour monitoring, pain assessments, skin assessments, depression screening) and monitoring forms were not used in all files where risk had been identified and documented in the progress notes.	In four of seven files reviewed nursing assessment tools were not used for acute changes in health condition for; a) two residents with chronic and acute pain, b) one resident who stated they felt depressed, and c) one resident with challenging behaviour.	<p>Ensure that assessments are documented for acute changes in health condition.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	There was evidence of the use of short-term care plans for wounds, and infections, however the care required for acute changes in health condition, although documented in the progress notes, was not always transferred to a care plan.	(i) Five of seven files reviewed did not have care plans documented for acute changes in health condition (chest infection, wounds and challenging behaviour); four of seven long term care plans did not have all identified interventions	<p>Ensure that care plans are documented for all identified care needs.</p> <p>90 days</p>

			documented to manage current needs.	
<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>	PA Low	<p>Assessments are completed on admission, and when the care plan is reviewed. Assessments were not always documented or a care plan developed, when there was a change in health condition noted in the progress notes (link 1.3.4.2 and 1.3.5.2). The RN reviews information gathered using the InterRAI assessments monitoring charts and other assessments (including but not limited to MNA, Waterlow, falls risk assessment tool) to develop the care plan.</p> <p>There were two wounds on the day of audit (one skin tear, and one BCC lesion.) Not all wound care plans were documented and not all wounds had been evaluated with each dressing change. There were no pressure injuries on day of audit. Adequate pressure management equipment and supplies were sighted.</p>	<p>(i) One of two wounds (BCC lesion) had no wound care plan documented.</p> <p>(ii) Two of two wounds did not have documented wound evaluations with each dressing change.</p>	<p>Ensure wound management plans are documented and wound progress is evaluated.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>The maintenance staff member completes the owners checks required for the building warrant of fitness. Hot water temperatures have not been checked or recorded since the installation of a new gas hot water system in May 2015.</p>	<p>Hot water temperature checks have not been completed for six months.</p>	<p>Undertake regular monitoring of hot water temperatures in resident areas to ensure that hot water temperatures meet all compliance requirements.</p>

				90 days
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Low	Results of infection control surveillance monitoring are discussed at the monthly staff meetings, however the infection control programme has not been formally reviewed in the past 12 months.	The infection control programme had not been reviewed in past 12 months.	<p>Ensure that the infection control programme is formally reviewed at least annually.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

---

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

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

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

No data to display
--------------------

End of the report.