# Torbay Rest Home Limited - Torbay Rest Home

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Torbay Rest Home Limited

**Premises audited:** Torbay Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 26 October 2017 End date: 26 October 2017

**Proposed changes to current services (if any):**  To convert one wing currently containing 10 rest home level rooms into a 10-bed dementia unit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 33

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

## General overview of the audit

Torbay rest home provides rest home level care for up to 52 residents including seven ‘supported living’ units. On the day of audit, there were 33 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.

A concurrent partial provisional audit was conducted to assess one ten-bed wing for suitability to provide dementia level care. The partial provisional audit included inspection of the wing to be converted and the areas of the rest home the conversion might impact, review of transition plan, also interview with the director, the nurse manager, the registered nurse and the cook.

The nurse manager has 20 years’ experience, including previous management experience in the aged care industry. She has been in the role since July 2016 and is supported by a registered nurse with aged care experience who is new to the role (two weeks) and still undergoing orientation.

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 certification audit identified improvements required in relation to informing family of incidents, registered nurse assessments and documentation and general practitioner (GP) documentation, care planning, medication prescribing and management of a respiratory outbreak.

The partial provisional audit identified that prior to occupancy, improvements are required around securing the dementia unit and gardens.

## 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. |  | Standards applicable to this service fully attained. |

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 medium or high risk and/or unattained 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' each have a 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 and medications are stored appropriately.

Food services and meals are prepared on-site. There has been 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 are 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 been checked and recorded regularly.

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

Partial provisional: The wing to be converted to a dementia unit has ten single rooms with ensuite toilets and hand basins on either side of a corridor with a lounge/dining area at the end of the corridor. There is a toilet and a separate shower at the end of the corridor near the entrance to the unit. The lounge has access to a large and attractive outdoor area, which is in the process of being secured.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse has attended external education and coordinate education and training for staff. Infection prevention and control is integrated into full staff meetings. There is a suite of infection control policies and guidelines to support practice. A monthly infection control report is completed for analysis.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 39 | 0 | 3 | 3 | 0 | 0 |
| **Criteria** | 0 | 87 | 0 | 3 | 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)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers 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 (three healthcare assistants, one registered nurse, one diversional therapist, one cook and one maintenance staff) confirmed their familiarity with the Code. Interviews with seven residents and three family members 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 ConsentConsumers 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 and family interviewed 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 SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | 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. Advocate support is available if requested. Interviews with staff, residents and relatives informed they are aware of advocacy and how to access an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers 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. Residents and relatives confirmed this and provided examples of a variety of community functions and groups they attend. 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 complaint form available. Information about complaints is provided on admission. The nurse manager and the RN operate an ‘open door’ policy. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.There is a complaint register. The complaints for 2017 (to date) were reviewed. There were no complaints made in 2016 and three complaints received in 2017 year to date. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed has been followed up and implemented. 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 DeliveryConsumers are informed of their rights. | FA | Posters display the Code and leaflets are available at reception. On entry to the service, the nurse manager 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 RespectConsumers 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 interviewed indicated that each resident’s spiritual needs are being met. Residents are supported to attend their own churches if they desire (confirmed in resident interviews) and church services are held in the home.Staff received training around abuse and neglect. There have been no reported instances of either.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | 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 and the Māori resident enjoys singing songs in Te Reo alongside the entertainers (observed during the audit). The residents care plan described appropriate cultural needs.Staff training includes cultural safety. One resident identified as Māori. The service is able to access Māori advisors through the Waitemata District Health Board and has links to a local Kaumatua.Discussions with care staff confirmed that they are aware of the need to respond to cultural differences.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that their cultural and individual values were being met, and these were included in care plans sampled.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility has implemented a code of conduct. The nurse manager supervises staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | 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 nurse manager is responsible for coordinating the internal audit programme. Monthly staff/quality meetings and regular residents’ meetings are conducted. There is a regular in-service education and training programme for staff. Staff interviewed stated that they feel supported by the nurse manager and RN. Evidence-based practice is evident, promoting and encouraging good practice. An RN is on-call when not on-site. A house general practitioner (GP) visits the facility between two to four hours per week. The service receives support from the local district health board (DHB). Physiotherapy services are available as required. A podiatrist visits every six to eight weeks. The service has links with the local community and encourages residents to remain independent. Residents and relatives interviewed spoke positively about the care and support provided. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | 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. Not all forms indicated family were informed following the adverse event. Relatives interviewed confirmed they are kept informed of any changes in their family member’s health status. Interpreter services are available if required. There were no residents living at the facility who were unable to understand or speak English.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Torbay Rest Home is owned and operated by an individual who also owns two other facilities in Auckland.Torbay Rest Home provides rest home level of care for up to 52 residents, which includes seven supported living units that are attached to the facility and approved to provide rest home level care. On the day of the audit, there were 33 rest home level residents including two respite residents and two rest home residents that live in the supported living units. All residents other than the respite residents were on the age-related residential care services agreement (ARCC) contract. This audit included a partial provisional unit to assess suitability to provide dementia level care in one wing, which is to be converted to a dementia wing.The nurse manager is a registered nurse and is on-site on a full-time basis, five days a week. The nurse manager has completed a minimum of eight hours of professional development over the past 12 months relating to the management of an aged care facility. A second registered nurse is employed five days a week.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.Partial provisional: The service has a documented transition plan to guide the service in providing dementia level services. The plan includes completing the securing of a wing, transitioning the rest home residents currently in the wing to other rooms (all have consented to this), prior to securing the unit and commencing a training programme so that all staff working in the unit complete the required NZQA standards in the required timeframes.The director owns another facility that provides dementia level care and both the nurse manager, and the registered nurse have experience working in dementia units. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | In the absence of the nurse manager, the staff RN is in charge, supported by the office administrator. The staff RN qualified overseas in 2010 and completed a bachelor of nursing programme in NZ. He has had two years’ experience in aged care in NZ, including working in dementia units, and has been employed by the service for two weeks. The nurse manager has had 20 years’ experience as an enrolled nurse, five years as an RN and 18 months as the manager at Torbay. She has also had experience working in dementia care. The office administrator has been employed by the service for 23 years. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management programme is in place. Interviews with the manager and care staff (three healthcare assistants, one registered nurse, one diversional therapist, one cook and one maintenance staff) reflected their understanding of the quality and risk management systems that have been put into place. Policies and procedures are provided by an external consultant and include interRAI procedures. A system of document control is in place with evidence of regular reviews. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes. Quality goals were documented in the staff meeting minutes. The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents, resident satisfaction and infection rates. Internal audits regularly monitor compliance. A corrective action form is completed where areas are identified for improvement. Staff are kept informed regarding results via staff meetings and during staff handovers. The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. There are annual resident satisfaction surveys completed. The resident satisfaction survey results have been correlated and no corrective actions were required.A health and safety programme is in place, which includes managing identified hazards. Health and safety is included in the monthly staff meetings and discussed at weekly meetings with the director. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data is collected and analysed monthly and a report documented for the monthly quality/staff meeting. Ten resident related incident forms were reviewed for July 2017. All 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. (Link to 1.3.3.4 for RN follow up) Adverse events are analysed each month and reported back to staff.Discussion with the nurse manager and RN confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. This was not completed as required following an outbreak (link 3.5.7). |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | 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. Eight staff files (one RN, four healthcare assistants, one cook, one cleaner and one activities coordinator) reviewed evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. The in-service education programme for 2016 has been completed and a plan for 2017 is being implemented. The nurse manager/RN and RN attend external training, which includes sessions provided by the Waitemata District Health Board. Annual staff appraisals were evident in all staff files reviewed. Both the nurse manager and RN have been trained in interRAI. Both the nurse manager and registered nurse are able to access training through the DHB, the hospice and other relevant external organisations.Partial provisional: Staff currently employed will staff the dementia unit. Two of the staff that will work in the unit have completed the required NZQA standards and one other is in the process of completing. The director and nurse manager are aware of the training requirements for staff working in dementia care and have a plan to ensure this occurs. All staff have received recent training around challenging behaviours and caring for residents with dementia. Challenging behaviour training was last provided in January 2016 and training around behaviour management, restraint minimisation and dementia in September 2017. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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. There are three healthcare assistants on morning shift, three on afternoon and two on night shift. The diversional therapist works four hours a day on Monday, Tuesday, Wednesday and Friday and six and a half hours on Thursday. Extra staff can be called on for increased resident requirements. Staff reported that staffing levels and the skill mix were appropriate and safe. Residents interviewed advised that they felt there are sufficient staffing. Partial provisional: The service has a draft roster which provides two healthcare assistants in the dementia unit on morning and afternoon shift and one overnight. The current two full time registered nurses (one of who is the nurse manager) will provide clinical oversight in the unit. The diversional therapist’s hours will be increased by four hours per day, four days per week. Current household and auxiliary staff will be able to meet the needs for the changed level of care for the residents. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | 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. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has a comprehensive suite of admission policies and procedures in place. Residents and family receive an information pack that includes lists of services provided, the admission process and entry to the service. All potential residents have a needs assessment completed prior to entry. The admission agreement aligns with the requirements of the ARRC contract. Residents and relatives six of seven resident files reviewed had a signed agreement. The other resident was on respite care. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | 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 using the yellow envelope system. The service ensures appropriate transfer of information occurs. Family interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The service has implemented an electronic medication management system. 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 medication for two respite residents and one long-term resident was administered without a medication chart signed by a medical practitioner. Medications were all safely stored. Eleven of 14 medication charts sampled met legislative prescribing requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The medication trolley is kept locked in the nursing station, which is also locked when not in use. All eye drops in use had been dated on opening and none were expired. Staff were observed during the lunchtime round to be safely administering medications. 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. The use of ‘as required’ (PRN) medications are monitored and electronically signed with times when administered. Medication charts sampled had photo identification and allergies/adverse reactions documented. All 14 medication charts documented the route of medications. The medication charts sampled identified that the GP had seen the resident three monthly and the medication chart was electronically signed. The RNs carry out weekly checks on emergency equipment. Oxygen cylinders are restrained in a locked cupboard. Sharps are disposed of into approved biohazard containers.The medication fridge temperatures are recorded regularly, and these are within acceptable ranges.Partial provisional: The staff working in the rest home will come into the dementia unit each medication time and administer medication in the unit. Medications will continue to be stored and managed as they are currently. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals and home baking are prepared and cooked on-site. There is a five-weekly seasonal menu in place which had been reviewed by a dietitian in August 2017. The cook is informed of resident dietary needs and changes. Likes and dislikes are accommodated. Additional or modified foods such as soft foods, pureed and vegetarian meals are able to be provided. Residents and family members interviewed were very complimentary about the meals provided. Meals are plated and delivered to the dining rooms (both close to the kitchen). Fridge and freezer temperatures are monitored and recorded daily. End cooked temperatures are recorded. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained. Partial provisional: The kitchen has the capacity to cater for dementia level residents. The cook, director and nurse manager reported that finger foods will be provided for residents for who they would be better suited than hot meals, and that food including sandwiches will be available 24 hours in the dementia unit. A small fridge has been purchased for the dementia unit to accommodate this.  |
| Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.  | FA | If the service declines an admission, the decision is communicated to the potential residents/family and the potential resident(s) are referred back to the referring agency for advice and a more appropriate placement.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The facility has embedded the interRAI assessment protocols within its current documentation. The RN is 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. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Care plans reviewed were overall personalised and demonstrated service integration and input from allied health. However not all care plans included specific interventions for all identified care needs. Care plan documentation sampled, reflected acute changes in health status. Family members interviewed confirmed they are very satisfied with the care delivery and support by staff. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The GP stated that he was satisfied with the care and that he is kept informed. The healthcare assistants and RN interviewed confirmed there is adequate equipment provided including continence and wound care supplies. Wound assessment, wound management and evaluation forms are available. There were no residents with wounds at the time of audit. Access to specialist advice and support is available through the local DHB. Monitoring forms are in use such as weight, blood pressure and behaviour charts. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The diversional therapist has worked at the service for many years and works 16 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, including dancing with an entertainer, 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. 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. Partial provisional: The service currently employs a qualified diversional therapist, who has previous experience working with people with dementia, and will be extending her hours by four hours per day, four days per week. There is a cupboard in the lounge in the proposed dementia unit where a variety of games are currently stored, and the nurse manager and director reported that additional activities suitable for residents with dementia are being purchased to allow healthcare assistants to have access to these when the diversional therapist is not present. The high resident staff ratio is intended to allow staff to provide impromptu activities to engage residents and support other behaviour management techniques. The diversional therapist will develop the programme and provide support to healthcare assistants. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In files sampled 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 each resident at least three monthly and more frequently for residents with more complex problems (link 1.3.3.4). Short-term care plans sighted had been evaluated and signed off as resolved. Staff stated that family members are informed of any changes to the care plan and this was evidenced in the family/visitor forms and in interviews with family members. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | Discussions with the registered nurse and nurse manager identified that the service has access to external and specialist providers. The service was able to describe the process they would use if the residents’ needs changed and the resident required a different level of care. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | 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 datasheets 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. Partial provisional: The current processes around the management of waste and hazardous substances will continue when the dementia unit commences operation. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building has a current building warrant of fitness that expires on 30 June 2018. A maintenance staff member works 40 hours per week and a contract gardener is available on call for facility maintenance matters after-hours. Reactive and preventative 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 been tested and recorded monthly and are maintained within a safe range. 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. Staff stated they have all the equipment required to provide the level of care documented in the care plans.Partial provisional: One wing that is currently partly occupied with rest home residents is to be converted to a secure dementia wing. It is not yet fully secured. The wing has five single rooms, each with an ensuite basin and toilet, down each side of the corridor, with a lounge/dining area at one end of the corridor that has the only access door to a large and well-presented outdoor area, which has been partially fenced, appropriate for dementia level residents. There is a toilet and a separate shower at one end of the corridor. Access to the unit is from the main resident lounge where residents gather for activities. This lounge has not been impacted by the change of the wing to dementia level care. Staff and residents reported that the lounge, which is now part of the dementia unit was rarely used by residents.The outdoor area has been fully fenced with an appropriate fence for a dementia unit. There are paths, raised gardens and seating areas. The outdoor area is accessed off the lounge and surrounds two side of the dementia unit. The garden can be accessed from or provide access to the main rest home lounge. This rest home lounge door is to be secured. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of communal toilets near communal areas. Five resident rooms have ensuites 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.Partial provisional: All 10 rooms in the proposed dementia unit either have an ensuite and /or a toilet and hand basin. Additionally, there is a communal toilet and there is one communal shower. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | There is adequate room to safely manoeuvre mobility aids in the resident bedrooms. Residents and family/whānau are encouraged to personalise their rooms.Partial provisional: All resident rooms in the proposed dementia unit are homely and suitable to meet the needs of residents with dementia. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | 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. Seating and space is arranged to allow both individual and group activities to occur.Partial provisional: The proposed dementia unit is accessed via the main rest home lounge. This lounge will not be impacted by the development of the dementia unit. The proposed dementia unit has an open plan lounge/dining area large enough to cater to the needs of the 10 residents. This lounge has a door onto the outdoor/garden area. Staff and residents interviewed reported that this lounge was not used a lot by rest home residents. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | 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. Residents and family/whānau interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes. Partial provisional: The current cleaning staff, laundry staff and laundry and cleaning process will continue when the dementia unit opens and are sufficient to meet the needs of the changed resident’s. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | 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.A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents’ rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.Partial provisional: The main door to the dementia unit requires replacing (link 1.4.2.2). The director reports that the door that is ordered will unlock automatically if the fire alarms sound, to allow safe evacuation of the proposed unit. There are no required changes to the evacuation plan as the footprint or placement of rooms and the lounge is not changing, other than ensuring the security door to enter the dementia unit releases if fire alarms are activated (link 1.4.2.2). The service has consulted a fire safety consultant who confirmed that no other changes are required. As the total number of residents is not changing the existing supplies for an emergency are sufficient. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.Partial provisional: Five of the rooms in the proposed dementia unit have external sliding doors, which are to be secured (link 1.4.2.2) and windows which provide plenty of natural light and ventilation. The windows have stays to prevent them from opening too far. The other five rooms and the lounge have windows that provide adequate light. The facility is heated with ceiling heating in communal areas. Individual rooms can be heated with oil heaters if required. The facility is well insulated, and the current residents are reported to very rarely request heating in their rooms. This will be monitored by staff. |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | 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 and responsibilities for the role is described in the job description. Infection control information is discussed at the staff meetings. Infection control education has been provided for staff. The infection control programme has been reviewed in the past 12 months.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at 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.  |
| Standard 3.3: Policies and proceduresDocumented 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. | FA | 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.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the ongoing education of staff and residents. The infection control coordinator, who has completed training to ensure knowledge of current practice, facilitates education. All infection control training has been documented and a record of attendance has been maintained. Education around infection prevention and control has been provided in March and February 2017. A 360-workplace hygiene audit was implemented and evidenced improvement between February and June 2017 evidencing improvement. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Low | 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 in Torbay’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. There has been one outbreak since the previous audit. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.9.1Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Interviews with relatives confirmed that they are kept informed, but this was unable to be consistently evidenced on completed accident/incident forms or in progress notes. | Three of ten incident forms sampled did not have documented evidence on the incident form or in the corresponding resident file that family were informed. | Ensure families are kept informed following accidents/incidents.60 days |
| Criterion 1.3.12.1A 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 legislation, protocols, and guidelines. | PA Moderate | The service has implemented an electronic medication management system. There are policies in place for safe medicine management that meet legislative requirements, however the organisational policies were not always followed. Eleven of fourteen medication charts sampled met legislative prescribing requirements. The medication for two respite residents was administered without a medication chart signed by a medical practitioner and another long-term resident’s medication chart had not been authorised by a GP. The medication trolley is kept locked in the nursing station which is also locked when not in use. | i) The two respite residents did not have medication charts or a copy of current prescriptions. ii) One long-term resident had medications listed by the pharmacy in the electronic medication system, but these had never been authorised by the GP. | i) Ensure that medication charts are provided for all residents and staff refer to these as per expected best practice. ii) Ensure that all medication charts are authorised by a GP prior to administration of medications.30 days |
| Criterion 1.3.3.4The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Moderate | Progress notes are written for each resident at least weekly or more frequently when required. A registered nurse reviews and signs off the healthcare assistant’s notes at least monthly but not always when a resident assessment is required. Staff reported an effective handover is provided at the beginning of each duty. | (i). Progress notes in three of seven resident files sampled did not evidence timely RN assessment including of reported changes in health, and incidents: Example: (a) Progress notes were written for a resident by an RN on the day of discharge from hospital one month prior to the audit, but there has been no RN progress note since. (b) Two residents had no documented RN progress note since late August 2017. (c) One resident with a chesty cough noted by healthcare assistants 10 days prior to the audit and recorded oxygen saturations of 83%, did not have a documented assessment by an RN and was not reviewed by a doctor for 10 days after this. Prior to this, healthcare assistant notes documented increased confusion and there was also no RN documented follow-up.(ii). Four of ten incident forms sampled did not have evidence documented of RN follow-up, either in the progress notes or on the incident form.(iii). Six of ten incident forms sampled had not been analysed by the registered nurse to identify potential interventions to minimise the likelihood of recurrence.(iv) One resident sees the GP independently and the service has no documentation from the GP about the visits. | (i)-(iii) Ensure there is documented evidence of regular resident reviews and timely review of residents by an RN including following a change in condition, and the analysis of incidents to identify interventions to minimise the risk of recurrence. (iv). Ensure the service has documented evidence of all resident reviews by a GP.60 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | All resident files sampled contained a care plan that was individualised and in which a variety of the identified needs were addressed. One of the six long-term care plans sampled (one resident was on respite) detailed interventions for all assessed needs.  | Five of six long-term care plans sampled did not address all identified needs. Example: (i) The care plan for one resident with non-insulin diabetes did not reflect the diagnosis or any required support. (ii) One resident with shortness of breath and atrial fibrillation requiring warfarin did not include the diagnosis and risks of the medication. (iii) One resident did not have the risks and support related to bradycardia documented. (iv) One resident’s care plan around behaviours that challenge did not include specific interventions to manage the behaviour. (v) The care plan for a resident with a stoma and history of angina did not include this diagnosis or relevant interventions. | Ensure care plans include all identified health and care needs.60 days |
| Criterion 1.4.2.4The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | The facility is well maintained and provides a safe environment for rest home level residents. There are alterations needed to ensure the unit is safe and secure for dementia level residents prior to occupancy. | Partial provisional: The dementia unit is not yet secure. This includes: (i) Five rooms with ranch sliders to the outdoors need securing. (ii) The ranch slider that leads from the rest home lounge to the dementia garden needs securing. (iii) The entry door needs to be secured and to be changed to meet fire safety requirements. | Partial provisional: Ensure the dementia unit is safe and secure prior to dementia residents occupying the unit.Prior to occupancy days |
| Criterion 3.5.7Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Low | All infections are documented on a paper based form and collated for surveillance and appropriately managed. Documentations demonstrated that while a respiratory outbreak in July 2017 was not managed as such, appropriate infection control measures for each resident were implemented. | A respiratory outbreak involving fourteen residents in July 2017 was not identified as an outbreak by the service or managed or reported as an outbreak. | Ensure all outbreaks are documented and reported as per best practice and requirements.90 days |

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

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

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

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

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End of the report.