APPQ Limited- Torbay Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	APPQ Limited
Premises audited:	Torbay Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 August 2018 End date: 3 August 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 34

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.

General overview of the audit

Torbay Rest Home provides rest home and dementia levels of care for up to 52 residents. During the audit there were 34 residents.

A provisional audit was conducted to assess a prospective new owner for Torbay Rest Home and to assess the current status of the service prior to purchase. This audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management. The prospective owner was also interviewed.

The nurse manager has over 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 staff registered nurse with aged care experience who has been in the role since October 2017.

Residents and families interviewed were positive about the care and services provided. An induction and in-service training programme are in place to provide staff with appropriate knowledge and skills to deliver care. The service has implemented comprehensive new care plans and evaluation templates.

The prospective owner has two other rest home level facilities in Auckland. The prospective owner intends to maintain the existing quality management system, and policies and procedures. A transition plan and business plan has been developed. The nurse manager and staff nurse will remain in their roles to support the new owner.

The audit has identified that four improvements are required in relation to incident reporting, interRAI assessments, resident reviews and the outdoor environment in the dementia wing.

Consumer rights

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

The prospective owner was interviewed to establish preparedness in owning and operating Torbay Rest Home. This person owns two other rest home level facilities in Auckland. It is the intention of the prospective owner to retain and maintain the current quality systems and processes, policies and procedures, existing staff and management.

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 is being implemented. 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. The prospective owner advised that rosters, staffing levels, and policies and procedures will remain as the status quo following transition to new ownership.

Continuum of service delivery

The senior 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 have a care plan, which is 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

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.

Restraint minimisation and safe practice

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

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 coordinates 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	42	0	3	0	0	0
Criteria	0	89	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with seven staff (two caregivers, one registered nurse, one activities coordinator, one cook, one cleaner and one maintenance staff) confirmed their familiarity with the Code. Interviews with seven residents and three family members (three dementia, one rest home) confirmed that the services being provided are in line with the Code. Aspects of the Code are discussed at resident and staff meetings. The prospective owner owns two other rest home level facilities in Auckland and is familiar with the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Informed consent processes are discussed with residents and families on admission. Written general consents reviewed in six resident files were signed by the resident or their enduring power of attorney (EPOA). Written consents were sighted for specific procedures. Advanced directives and/or resuscitation status are signed for

		separately by the competent resident. Copies of EPOA are kept on the resident's file where required. Caregivers and registered nurses (RN) interviewed, confirmed verbal consent is obtained when delivering care. Resident files of long-term residents have signed admission agreements.
Standard 1.1.11: Advocacy And Support Service 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 and on complaints forms. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service also 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 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. 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 are complaint forms available at the entrance to the facility. Information about complaints is provided on admission. The nurse manager and the staff 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 2018 were reviewed. There has been one complaint received (year to date). Documentation including follow-up letters and resolution,

		demonstrated that this complaint was managed in accordance with guidelines set by the 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 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 about the Code 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 and their privacy maintained. 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 and church services are held in the home. Staff received training around resident abuse and neglect. There have been no reported instances of either.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan documented for the service. Activities include Māori entertainers. Staff training covers cultural safety. Discussions with care staff confirmed that they are aware of the need to respond to cultural differences. One resident identified as Māori. A Māori assessment has been

		completed that has included input from the resident and their whānau. No specific needs were identified. The service is able to access Māori advisors through the Waitemata District Health Board and has links to a local kaumātua.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	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 documented in care plans sampled.
Standard 1.1.7: Discrimination Consumers 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 respect 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/house rules.
Standard 1.1.8: Good Practice Consumers 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 cover pre-employment processes and the new employee's requirement to attend orientation and ongoing in-service training. The nurse manager is responsible for coordinating the internal audit programme. Monthly staff 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 staff RN. Evidence-based practice is evident, promoting and encouraging good practice. The roster indicates the on-call RN when an RN is not on-site. A house general practitioner (GP) visits the facility twice 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: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	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. Family notification is also documented in the residents' progress notes with a designated stamp to alert staff. A notification consent form identifies situations that family wish to be contacted. All ten incident/accident forms reviewed indicated family were informed following an adverse event if they indicated that they wanted to be informed. There were two instances where an incident report had not been completed (link 1.2.4.3). Relatives interviewed confirmed they are kept informed of any changes in their family member's health status. Interpreter services are available if required. Family and staff are used in the first instance. There was one (respite) resident who did not speak English. Staff and family were used as interpreters. The facility is trialling a phone application for interpreter services. Communication is also available via pictures on cards.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Torbay Rest Home provides rest home and dementia levels of care for up to 52 residents. This includes ten dementia beds, seven supported living units that are attached to the facility and approved to provide rest home level care and 35 rest home level beds. On the day of the audit, there were twenty-nine rest home level residents, which included one respite resident and two rest home residents that live in the supported living units. There were five dementia level residents. All residents

		other than the respite residents were on the age-related residential care services agreement (ARCC) contract. This provisional audit included an interview with the prospective owner. This person has owned two rest home level facilities in Auckland since 2011. The prospective owner also owned one dementia care facility in Whangarei but sold the facility after one year due to its distance from Auckland. She advised that she intends to maintain the existing quality management system, and policies and procedures. A transition plan and business plan has been developed. The current organisation has established business goals and a quality and risk management plan. Advised that the owner intends to be on-site at Torbay Rest Home four-five days a week for three-four hours each day to familiarise herself with the running of the service and that staffing levels will remain unchanged. The nurse manager and staff nurse will remain in their roles to support the new owner. The prospective owner stated that she does not plan to work at the rest home in a manager's role. The nurse manager is a registered nurse and is on-site on a full-time basis, five days a week. She has over 20 years' experience as an enrolled nurse, five years as an RN and has been the nurse manager at Torbay Rest Home since July 2016. She has completed a minimum of eight hours of professional development over the past 12 months relating to the management of an aged care facility. She is supported by a staff registered nurse who is employed five days a week.
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. The staff RN qualified overseas in 2010 and completed a bachelor of nursing programme in NZ. He has two years' experience in aged care in NZ and has been employed by Torbay Rest Home since October 2017.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained	FA	A quality and risk management programme is in place. Interviews with the nurse manager and staff reflected their understanding of the quality and risk management systems that have been put into place.

quality and risk management system that reflects continuous quality improvement principles.		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. The prospective owner advised of her intention to retain the current suite of policies and procedures. Quality goals are documented. The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents, resident satisfaction and infection rates. Adverse events are also trended individually by resident. Internal audits regularly monitor compliance. A corrective action form is completed where areas are 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. Annual resident satisfaction surveys are completed. The last resident satisfaction survey results (2017) have been correlated and no corrective actions were required. A health and safety programme is in place, which includes managing identified hazards. The nurse manager oversees the programme. She is supported by two health and safety representatives (maintenance and administrator). Health and safety training begins during the new employee's orientation. The topic of health and safety is discussed each month in the staff meetings. The hazard register is regularly reviewed and updated as new hazards are identified. 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.	PA Low	The service collects all incident and accident information reported by staff on a paper-based system. Incident and accident data are collected and analysed monthly and a report is documented and shared at the monthly staff meetings. Ten resident related incident forms were reviewed for 2018. The accident/incident forms that were selected for review indicated that immediate action had been taken, including half-hourly neurology

		observations for any suspected head injury. There was evidence of two incidents where residents had fallen and were safely lowered to the floor by staff. No incident reports were completed to document these two adverse events. Discussion with the nurse manager and RN confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications with an example provided when police were involved with a resident who wandered away from the facility.
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. Seven staff files (one RN, three caregivers, one cook, one kitchen assistant, and one cleaner) 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 2017 has been completed and the education plan for 2018 is being implemented. The nurse manager/RN and staff RN attend external training, which includes sessions provided by the Waitemata District Health Board. The staff RN has 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. Nine staff are currently employed in the dementia unit that opened in January 2018. Three of the staff that work in the unit have completed the required NZQA standards and four are in the process of completing theirs. The remaining two staff have only recently been employed. All care staff have received recent in-service training around challenging behaviours and caring for residents with dementia (13 March 2018).

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 nurse manager) with on-site cover provided Monday – Friday. One RN is rostered on-call when not available on-site. The rest home roster reviewed covers 29 rest home level residents. There are four caregivers on the morning shift (two eight hour shifts and two short shifts (7.00 am – 1.00 pm), three on afternoon (two eight hour shifts and one short shift (4.00 pm – 9.00 pm) and two on night shift. Five residents were living in the dementia unit. One caregiver is rostered on each shift (morning, afternoon and night). The activities coordinator is employed five days a week from 9.30 am – 2.30 pm. Two cleaners are employed Monday – Friday and one laundry staff works Monday – Friday and Saturday mornings. 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 was sufficient staffing. The new owner stated that she does not plan to adjust staffing levels in either the rest home or the dementia unit based on the current occupancy.
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 nurses' station. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregivers 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 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, as well as information around the secure dementia unit. Potential residents have a needs assessment completed prior to entry. The admission agreement aligns with the requirements of the ARRC contract. Five 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.	FA	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. One respite resident has a signed prescription chart and blister packed medication. Medications were all safely stored. Twelve of twelve 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 for dementia and rest home 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 regarding 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 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.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service 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 can be provided. Residents and family members interviewed were very complimentary about the meals provided. Meals are plated and delivered to the dining rooms and transported to the dementia unit in a hot box. 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. Food including sandwiches, are available 24 hours in the dementia unit. The food control plan has been applied for and is in progress.

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 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 (link to 1.3.3.3 for timeframes).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The service has implemented a new care plan template. The template is comprehensive and covers all aspects of care. Of the six resident files reviewed, five had been moved to the new format. Care plans reviewed (both old and new format) were comprehensive and reflected interRAI assessments. Short-term care plans were documented for short-term needs and these were files with the long-term care plan in the resident's file. Care plans reviewed demonstrated service integration and input from allied health. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Residents (if appropriate) and family stated they were involved in the care planning and review process. Behaviour management including triggers, interventions and successful de-escalation techniques were included in the long-term care plan in the two dementia care resident files reviewed.
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 family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the RN initiates a review and if required a GP review. Short-term care plans

		are developed for infections. Continence products are available and specialist continence advice is available as needed. The stoma nurse had provided help and support as needed to a resident with a stoma. The caregivers 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 four residents with wounds at the time of audit, three with minor skin tears and one with a stage two pressure injury. All wounds have an assessment, wound management plan and evaluation. Access to specialist advice and support is available through the local DHB. Monitoring forms are in use such as weight, blood pressure repositioning and behaviour charts.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The service employs an activities person five day a week for five hours a day. Prior to this role she was a caregiver at the facility and has been in the role of activities coordinator for a year. The programme is Monday to Friday and integrated to meet the physical and psychosocial well-being of the residents. The dementia unit has a separate activities programme supported by the caregivers. Dementia care residents also join in with the rest home activities. 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. An activities assessment and ‘my life story’ is completed on admission

		and an individual activity plan developed. Individual activity plans were seen in long-term resident files. The activities person is involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through resident meetings and direct feedback from residents and families.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	In files sampled, the comprehensive 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 1.3.3.3 as interRAI have not always been six monthly). 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 identified that the service has access to external and specialist providers. The service was able to describe the process they would use if a resident's 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.
Standard 1.4.2: Facility Specifications	PA Low	The building has a current building warrant of fitness that expires on

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		30 June 2019. 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. The dementia unit and garden are fully secure. There are paths, raised gardens and seating areas. One pathway leading from the door needs a guard rail as it is slightly raised from the garden and lawn. The outdoor area is accessed off the lounge and surrounds two side of the dementia unit. The prospective owner advised there are no plans at this stage to make changes to the environment except continuing with ongoing maintenance.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	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.
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.
Standard 1.4.5: Communal Areas For Entertainment, Recreation,	FA	Communal areas within the facility include open plan lounges and

And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		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 are arranged to allow both individual and group activities to occur. The dementia unit has an open plan lounge/dining area large enough. This lounge has a door onto the outdoor/garden area.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are 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.
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 with the last drill taking place on 11 July 2018. 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. 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. There is short-term back-up power for emergency lighting. 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 to their bed and in the toilet. Residents who are at risk of

		falling or who are unable to activate the call system next to their bed also wear a watch alarm that is activated either manually or if they fall.
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. The facility is heated with ceiling heating in communal areas. Individual rooms can be heated with oil heaters if required. The facility was warm and comfortable on the day of audit.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Torbay has an established infection control (IC) programme that is appropriate for the size, complexity and degree of risk associated with the service. The staff 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 programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme at Torbay. The infection control (IC) nurse has completed education in infection control in the 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 procedures 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	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.

provided.		
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 as part of the annual training plan.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	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 to the quality management programme. Outcomes and actions are discussed at quality meetings. There have been no outbreaks since the previous audit. The nurse manager is aware of the need to inform public health and the DHB should an outbreak occur.
Standard 2.1.1: Restraint minimisation Services 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. The staff RN is the designated restraint coordinator. Staff interviews, and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers was last provided on 3 July 2018. There were no residents with restraints or enablers at the time of the audit. Prior to the audit, there was one episode of environmental restraint. All appropriate steps were taken to ensure that this episode of restraint was a last resort. Consent for environmental restraint was

		given by the resident's EPOA.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.4.3 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.	PA Low	Systems are in being implemented for the recording of adverse events with appropriate follow-up actions taken including neurology observations if there is a suspected injury to the head. An RN investigates each adverse event and the nurse manager signs off when the investigation is completed. There were two instances of incidents that did not prompt staff to complete an accident/incident form.	Two adverse events (near misses) were documented in the residents’ progress notes indicating that a resident had been safely lowered to the floor by staff. There was no evidence of either of these events being recorded on incident forms. The staff RN was unaware that an accident/incident form was required to document these events.	Ensure all adverse events, including those that do not reflect harm, are recorded on accident/incident forms. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time	PA Low	The interRAI process is included as part of the initial assessment and evaluation process. These have not always been completed within set timeframes. The staff RN reported that he is currently working towards getting all interRAI	Two of three interRAI assessments were not completed within timeframes for rest home level of care. One new resident in the dementia unit did not have the initial interRAI within 21 days.	Ensure that interRAI assessments are documented within set timeframes.

frames that safely meet the needs of the consumer.		assessments up to date along with the review of all care plans. Previously, the process had been that the residents with the highest needs were updated first.		60 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Progress notes are written for each resident at least weekly or more frequently when required. A registered nurse reviews and signs off the caregiver's progress notes two to four weekly, but progress notes did not always reflect RN follow up when a resident had documented changes in health status. Staff and the RN interviewed reported that the RN does follow up all reports. Staff reported an effective handover is provided at the beginning of each duty.	Two rest home residents had a reported 'red sacrum' documented in the progress notes, had there was no documented follow-up by the RN.	Ensure there is documented evidence of regular resident reviews and timely review of residents by an RN including following a change in health status. 60 days
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Low	The dementia unit has a secure garden and indoor environment. There are alterations needed to ensure that the drop at the edge of the pathway to the lawn in the secure dementia wing is not hazardous for residents.	The pathway slope from the dementia unit door to the garden has a short drop at one edge to the lawn and is a hazard to residents.	Ensure the outdoor pathway in the dementia wing has a guard rail to prevent residents tripping over the edge of the path. 60 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.

No data to display

End of the report.