

G A & H J Lydford

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 HealthShare 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: G A & H J Lydford

Premises audited: Tarahill Resthome

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 8 October 2018 End date: 9 October 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: 16

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Tarahill Rest Home provides rest home level care for up to 19 residents. Short stay/respice care can be provided subject to bed availability. Day to day operations and governance is provided by two directors, one of whom is the designated nurse manager (NM) and the other oversees the building, grounds, equipment and procurement. There have been no significant changes to the service since the previous surveillance audit in 2017.

This re-certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the directors, staff, and a general practitioner (GP). The GP, residents and families spoke positively about the care provided.

There were no areas requiring improvement identified as a result of this audit. Food and nutritional services were rated as continuous improvement.

Consumer rights

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

Standards applicable to this service fully attained.

Information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. Information is provided to residents and their families on entry to the service and when requested. Residents and family members confirmed their rights are met, staff are respectful of their needs and communication is appropriate. Consent forms are provided, and residents and family are given relevant information regarding consent processes. Residents and family/whanau are assisted and encouraged to formulate advance directives.

Professional boundaries are understood by staff and maintained. Service delivery is based on good practice principles. Advocacy information is available for residents and family/whanau. Care is guided by a Maori health care plan and other related policies. Links with family/whanau and the community are encouraged and supported by the service provider.

A complaints register is maintained and any complaints received are resolved promptly and effectively

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.

An annual business plan describes the scope, direction, goals, values and mission statement of the organisation. The directors and designated staff are monitoring all aspects of the services provided. The director/nurse manager has been in the role for many years and is an experienced registered nurse who is suitably qualified to manage an aged care service.

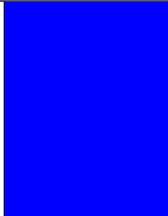
The quality and risk management system collects quality data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented, investigated and any causes are remedied to prevent recurrence.

Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. Policies were current and are reviewed and updated as needed at regular intervals.

The appointment, orientation and management of staff is based on current good practice. There is a systematic approach for identifying and delivering staff education. This supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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.		All standards applicable to this service fully attained with some standards exceeded.
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The admission process is managed by the nurse manager (NM) and the registered nurse (RN). The general practitioner (GP) is involved in the admission process and three-monthly reviews of medications or as required. Residents' medical admission is completed in a timely manner. The nursing team is responsible for developing the care plans. Care plans and interRAI assessments are completed in a timely manner.

There are policies and procedures that clearly document the service provider's responsibilities in relation to each stage of medicine management. The service uses pre-packed medication system and an electronic medication system for e-prescribing, dispensing and administration of medicines. All medication administration competencies are current.

Food, fluid and nutritional needs of residents are provided in line with the recognised nutritional guidelines appropriate to the residents' needs.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents. All internal and external areas are clean and the building and chattels are well maintained. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible and safe for residents' use.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

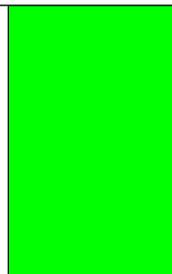


Standards applicable to this service fully attained.

Tarahill Rest Home has a philosophy and practice of no restraint. There were no restraints in use. On the days of audit, enablers such as bed levers and transfer belts were in use to promote independence and to keep residents safe. These were consented to by the residents using them. Policies and procedures meet the requirements if a restraint is required and staff education is ongoing.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection control programme is developed in consultation with the relevant key stakeholders. The environment is managed in a way that minimises the risk of infection to residents, staff and visitors. The ICC is responsible for monitoring infections, surveillance of data, trends and implementing relevant strategies. The NM is the infection control coordinator. There was no infection outbreak reported.

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	1	44	0	0	0	0	0
Criteria	1	92	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>There are policies and procedures in place to ensure residents' rights are respected by staff. Interviewed staff demonstrated knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the staff training education programmes. On the days of the audit, staff demonstrated knowledge of the Code when interacting with residents. The residents and family/whanau reported that staff respect their rights and are incorporated as part of their everyday practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Policies and procedures on consent support the residents' right to make informed decisions. The NM reported that informed consent is discussed and recorded at the time the resident is admitted. The residents' files sampled had the required consent forms signed by residents and where appropriate, by the enduring power of attorney (EPOA). The policy references Rights 5, 6 and 7 of the Code and the process for determining competency and advanced directives. Open disclosure is practised and documented when family are contacted. Staff acknowledged the residents' right to make choices based on information presented to them. Family/whanau interviewed confirmed that residents were provided with day to day choices and consent was obtained. The GP interviewed reported satisfaction with communication from staff.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>There were appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. The advocacy policy details contact information for the Health and Disability Commission and Age Concern advocacy services. Information about the right to advocacy and contact details for local services is included in the information given and explained to residents and families on admission. Staff training on the right to advocacy / support is provided annually and staff demonstrated understanding of how residents can access advocacy/support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and relatives are encouraged to visit at any time. Residents and family/whānau reported that there were no restrictions to visiting hours. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of this standard and Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed said they felt comfortable and wouldn't hesitate to raise a concern if they had one. The director/nurse manager is responsible for complaints management and follow up but all staff interviewed confirmed a sound understanding of the complaint process and what actions are required of them.</p> <p>The complaints register reviewed recorded a total of one complaint received this year and no others since 2015. Review of the documents related to the most recent complaint, interviews with staff and the NM revealed that the matter was promptly and fully investigated and definitive action was taken as a result.</p> <p>There have been no complaints to the Health and Disability Commissioner (HDC) nor any requests for advocacy services to provide support in the last certification period.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	FA	<p>Information about the Code and the Nationwide Health and Disability Advocacy Services are displayed in the facility. The nurse manager (NM) reported that an advocate visits the service and can be accessed as required.</p>

rights.		Residents and family/whanau interviewed were aware of their rights and confirmed that information was provided to them during the admission process. Information pack was sighted and outlines the services offered. Signed residents' agreements were sighted and meet the requirements of this standard and district health board requirements.
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 privacy and dignity policy explains how staff are to ensure the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed and the care planning process identifies and records interventions for respecting residents' individual beliefs and values. The service has single, ensuite and shared rooms which maintain physical, visual, auditory and personal privacy. Residents' personal belongings are maintained in a secure manner. There are documented policies and procedures on abuse and neglect including the required reporting process.
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 Maori perspective on health is documented and includes Maori models of Health and barriers to access. Terminal care and death of the Maori resident is included. There is access to cultural advice, resources and documented procedures to ensure recognition of Maori values and beliefs. Cultural safety training is provided to all staff.
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	Cultural needs are determined on admission and a management plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the principles of the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident. Residents' values and beliefs are discussed and incorporated into the care plan. Residents and family/whanau members interviewed confirmed they are encouraged to be involved in the development of long-term care plan. In interviews conducted, staff demonstrated an understanding of cultural safety in relation to care.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment,	FA	Policies sighted evidence processes for providing an environment that is free from discrimination, coercion, harassment, sexual, financial or other exploitation. The staff code of conduct and professional behaviour is included in the employment and orientation process. Staff demonstrated

sexual, financial, or other exploitation.		an awareness of the importance of maintaining boundaries with residents. Residents and family/whanau reported that staff maintain appropriate professional boundaries. The NM, demonstrated awareness of the importance of maintaining professional boundaries and processes they are required to adhere to.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	There are systems in place to ensure staff receive a wide range of opportunities which promote good practice. Staff reported that they were satisfied with the relevance of the education provided and were able to explain how they maintain good practice. Policies and procedures are linked to evidence-based practice and treatment protocols. There are regular visits by the GP and allied health providers as required. The nursing team is available and accessible to care staff for clinical support and advice when required.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Staff education has been provided related to appropriate communication methods. The service has required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed. Documentation regarding open disclosure following incidents/accidents was evident. Residents and family/whanau reported that they are informed of any events or concerns.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The business plan which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. This document describes annual and longer-term objectives and refers to other associated operational plans. Interview with both director/operators and documents reviewed verified effective methods for ensuring services are provided in ways to meet the needs of all residents.</p> <p>The director/nurse manager is a registered psychiatric nurse (RPN) with a current practicing certificate and has been in the role of manager for 22 years. This person demonstrated knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing professional development in nursing and at least eight hours of education per annum as required in the agreement with the DHB.</p> <p>The service holds contracts with the DHB, for rest home level care and respite. There were no people under the age of 65 years staying in the facility nor any for respite/short stay care on the days of audit. The facility has a maximum capacity of 19 beds. On the days of audit 16 beds were occupied.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The full time and long-time employed diversional therapist/senior caregiver is nominated as second in charge. This person carries out all the required duties under delegated authority when the director/nurse manager is absent with input from the part time registered nurse (RN). The RN is experienced in the aged care sector, has a current practising certificate, knows all the residents well and shares the on-call roster with the nurse manager. Staff reported the arrangements for covering the nurse manager work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Tarahill Rest Home has well established quality and risk management systems for determining compliance and identifying where improvement is needed. Service delivery monitoring includes collation and analysis of incidents/accidents, complaints and infections, and the outcomes of internal audits. Resident and family satisfaction surveys are conducted regularly on different service areas and an overall survey completed annually. The most recent family survey produced a high (100%) rate of return with a high satisfaction rate of 100%. Furthermore, feedback about all aspects of service provision is actively sought from all residents at their monthly meetings.</p> <p>Minutes from the directors/management and staff meetings reviewed confirmed that service delivery information is reported and discussed. Staff reported their involvement in quality and risk management activities through being informed about quality and risk activities, and via the staff education programme.</p> <p>Where service shortfalls are identified (from feedback or internal audits) relevant corrective actions are decided and implemented. Corrective or preventative actions were also noted on incident forms. Evidence that these matters are clearly communicated back to staff was confirmed by staff interview who said they receive memos or verbally at handover or meetings. The service is reducing falls via its falls management programme and has eliminated medicine errors since the introduction of an electronic medication system in August 2017.</p> <p>The policies cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The directors described their processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. Both are familiar with the Health and Safety at Work Act (2015) and its requirements. The diversional therapist interviewed, is the nominated health and safety officer and has achieved stage one education relative to the role. This person manages all</p>

		<p>reported hazards, conducts environmental inspections, provides education and mentoring about safe lifting/manual handling and inducts all new staff to the health and safety systems in place. There have been no staff injuries in this audit period.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse events on accident/incident forms. A sample of forms from 2017-2018 were consistent in clearly describing and detailing the incident and recording who had been notified. Each unwitnessed fall event had attached records of post fall neurological observations. The director/nurse manager reviews all incidents, investigates where necessary and documents preventative actions which are followed-up. This person demonstrated understanding about essential notification reporting requirements, including for pressure injuries and advised there have been no events requiring notification to the Ministry of Health, or the DHB since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Staff management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. Copies of practising certificates for the registered health practitioners are on file. A sample of staff records reviewed, confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period and then annually.</p> <p>Continuing education is planned on an annual basis and occurs each month. These include mandatory training requirements such as fire drills, first aid and medicines competency for those who administer medicines and other education to meet the requirements of the provider's agreement with the DHB. A majority of carers have educational achievements related to care of older people. The staff records reviewed demonstrated attendance at ongoing training and completion of annual performance appraisals.</p> <p>The nurse manager and the part time employed registered nurse are trained and are maintaining their annual competency requirements to undertake interRAI assessments. Approval for the nurse manager who is a registered psychiatric nurse to complete interRAI assessments has been granted subject to the part time RN reviewing and signing off the assessments completed by the NM.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. Observations and review of the monthly roster confirmed more than adequate staff cover has been provided, with staff replaced in any unplanned absence. There is always at least one staff member with a current first aid certificate on site. The directors and care staff interviewed stated that staffing levels are adjusted to meet the changing needs of residents. The directors live on site and are available afterhours or another RN is allocated on call duties if they are unavailable. Staff stated that ready access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. The residents and family interviewed supported this.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Residents' information is entered into the files on admission by the NM or RN. A register is kept for current and past records. Resident information is stored securely in the nurses' station. Review of resident records indicated they include reports from all health professionals. Daily progress notes are maintained, and records are integrated. Entries are legible, dated, signed and designated. Archived records are stored for 10 years in a secure and safe manner, these are retrievable as required.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' admission process is managed by the NM and the RN. The facility brochure is clearly documented, and access processes and entry criteria are communicated to the consumers, their family/whanau where appropriate, local communities and referral agencies. Admission forms are completed, and information pamphlets and the facility brochure are provided at pre-entry stage.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a</p>	FA	<p>There are policies and procedures in place that clearly document the service provider's responsibilities in each stage of medicine management. All staff responsible for medication administration are competent with current competencies. Medication management training records were sighted. The service uses an electronic medication system. Three monthly medication</p>

<p>safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>reviews are completed by the GP. Allergies or sensitivities are indicated and residents' photos are used as part of the identification method.</p> <p>The caregiver was observed administering medication. Safe practice which complied with legislation and guidelines was demonstrated. There are controlled drugs on site and weekly and six-monthly stock takes were completed. Medication is safely stored in locked cupboards. There were no expired medications on site.</p> <p>There is a policy for medication self-administration that guides staff on the process for safe self-administration. There was a resident who was self-administering eye-drops and was assessed as competent by the GP. Medication audits are conducted, and corrective actions are acted upon.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>CI</p>	<p>Food, fluid and snacks are available 24 hours a day and all residents interviewed commented on the quality and variety of meals. An experienced and qualified cook is employed to oversee food services and is on site Monday to Friday for lunch and dinner. Kitchen assistants are rostered for the weekends.</p> <p>The four weekly, seasonal menu was reviewed by a registered dietitian in March 2018 which resulted in no significant changes being required. Residents requiring special or modified diets are catered for. On the days of audit there were two residents requiring diabetic diets. Residents interviewed raved about the meals and commented that they are always provided with alternative food they prefer. The high level of resident satisfaction attained for food services is an area of continuous improvement.</p> <p>Tarahill Rest Home has registered their food control plan with the District Council and onsite audit was scheduled to occur in the days following this audit. A letter confirming this was dated 19 July 2018.</p> <p>Food is stored safely with use by or dates plated seen on each item. Fridge/freezer and hot meal temperatures are recorded daily.</p> <p>There have been no reported concerns about food services. On the days of audit, staff were observed to be offering residents hot and cold drinks in their bedrooms and the communal areas. A water dispenser is located in the dining room and residents are also provided drinking water in their rooms. Each resident is weighed monthly and any weight loss is investigated. Supplements are provided to residents whose weight is causing concern.</p>
<p>Standard 1.3.2: Declining</p>	<p>FA</p>	<p>A process is in place for managing immediate risk to the consumer and/or their family/whanau</p>

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>when entry to service is declined and a record is kept. When entry to services has been declined, the consumer and where appropriate their family/whānau are advised of the reason for the decline and are given options or alternative services.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Initial assessment tools are used to assess the residents' needs, support requirements and preferences on admission. InterRAI assessments are completed in a timely manner. The assessed needs, outcomes and goals identified through the assessment process are documented to serve as a basis for service delivery. Assessments are conducted in a safe and appropriate setting as confirmed by the interviewed GP. Assessment outcomes are communicated to the residents and/or their family/whānau and referrers and relevant service providers.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans sampled were resident focussed, integrated and provide continuity of service delivery. Short term and wound care plans are completed as when required. Residents, their family/whānau and relevant key workers are involved in the care planning process. The care plans sampled described the required support to achieve the desired outcomes identified by the ongoing assessment process. Service integration was sighted in the sampled residents' files.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The documented interventions in short term care plans and long-term care plans are sufficient to address the residents' assessed needs and desired goals/outcomes. Interventions are updated when required and interRAI triggered outcomes are addressed. Specialist advice is sought from other service providers and specialist services when required. Referral documents to other services and organisations involved in residents' support were sighted in the sampled files. Interviewed families, residents and staff reported that they were satisfied with the services provided. Interviewed staff reported that there are adequate resources to meet safe resident care. Adequate medical/clinical resources were sighted and were appropriate to the size of the facility.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their</p>	FA	<p>Activities are planned by the diversional therapist (DT). A monthly planner is posted on the activities boards that are accessible to residents. A resident preference/choice of activities form is completed on admission. The activities provided take into consideration residents' interests and ability. Residents and their family/whānau are consulted in the activities assessment and planning</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>process. There is a wide range of activities offered: including bingo; quiz; music sessions; walking groups; stroke club, art and craft. There is community involvement with external entertainers invited, church and music groups. Monthly activities attendance checklist is completed, and documentation was sighted. Evaluation of the individual activity plans are completed six monthly.</p> <p>Van outings are conducted once a week to areas of interest.. Monthly residents' meetings are conducted, and outcomes are implemented and communicated to family/whanau and residents. Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' long-term care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes. Family/whanau and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.</p>
<p>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.</p>	FA	<p>Residents are referred to other health and disability service providers when required. Referral documents were sighted in the sampled files. The NM, RN and the GP are involved in the referral process in consultation with the resident and/or their family where appropriate. Informed consent, general consent forms and referral documentation was sighted in records sampled. Residents and/or their family are given the choice and advised of their options to access other health and disability services where indicated.</p>
<p>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.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. Staff who handle chemicals are provided with education on the safe use of chemicals. Chemical safety data is on display where the chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Protective clothing and equipment is provided and staff were observed to be using this.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The building warrant of fitness is current and expires on 19 June 2019.</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Tasks scheduled in the building maintenance programme are carried out at regular intervals. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with the director, the health and safety officer and on-site visual inspections. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. External areas are safely maintained and are appropriate to the resident group and setting.</p> <p>Residents and staff confirmed they know the processes they should follow if any repairs or maintenance is required. They said requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is an adequate number of accessible bathroom and toilet amenities which are located in each wing of the facility, and are in close proximity to residents' bedrooms. One bedroom has an ensuite bathroom. All bedrooms have a washbasin with hot and cold running water. Hot water temperature is regulated by tempering valves and monitoring of the temperatures at the tap is carried out monthly. The temperature records sighted show hot water is delivered within a safe range of temperatures. Residents interviewed were very happy with the provision, cleanliness of and access to ablution areas. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Two of the bedrooms are twin share, although only occupied by one person at time of audit, and all others are single occupation. Rooms are personalised with furnishings, photos and other personal items displayed. Each room is unique in its size and shape and can easily accommodate a bed, seating and other furniture. There are additional rooms and spaces for storage of mobility aids, wheel chairs and mobility scooters. Family and residents expressed satisfaction with their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and</p>	<p>FA</p>	<p>This is a small rest home with a spacious and welcoming communal lounge and a separate dining room for residents both of which are within easy walking distance from residents' rooms. The lounge is used for activities and has varied seating configurations if someone doesn't want to participate in the programme. All residents can easily access their rooms for privacy, if required.</p>

<p>accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Care staff provide the laundry services. Staff interviewed about laundry demonstrated good knowledge of laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and that their clothes are returned in a timely manner. The cleaner is employed for sufficient hours Monday to Friday. This person changes each resident's bed linen once a week and stated there is sufficient time allocated for completing daily/weekly tasks. The care staff carry out cleaning tasks such as rubbish removal, light dusting and bathroom cleaning on the weekend. All staff have attended training in the safe handling of the chemicals on site and in health and safety matters, as confirmed by review of personnel files and interviews with staff including the cleaner. Bulk chemicals are stored in a lockable room when not in use and are decanted into clearly labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. All areas of the facility were spotless on audit days. The residents and family members interviewed were happy with the cleanliness of their rooms and other areas in the home</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are current and are known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency.</p> <p>A fire evacuation plan has been approved. Trial evacuations take place every six months and a copy of the finding from each drill is sent to the local fire service. The most recent drills occurred on 11 May 2018 and is scheduled to occur again in November. The time taken for evacuation is recorded and there have been no issues or risks identified. The most vulnerable or mobility impaired residents are listed on the fire board and are assisted first. The new staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for a maximum of 19 residents. Emergency lighting is regularly tested.</p> <p>The call bell system was functional on audit days and staff were observed to attend to these in a timely manner. Residents and families were happy with staff responses to call bells at all times of the day and night.</p>

		Staff lock the external doors and windows each night for security purposes.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by electric 'night stores' in communal areas and individually temperature-controlled panel heaters in residents' rooms. Areas were warm and well ventilated throughout the audit and residents and families confirmed the home is maintained at a comfortable temperature year-round.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There is an infection prevention and control programme which minimises risk of infection to residents, staff and visitors. The infection control programme is reviewed annually with documentation sighted. The programme is appropriate to the size and nature of the service. Infection control policies and procedures clearly define the responsibility of infection control and there are clear lines of accountability for infection control matters in the organisation. There are infection control posters and disinfection agents at the front entrance to increase awareness to residents, staff and visitors on prevention and minimising spread of infections.</p> <p>Staff, residents and visitors with infectious conditions or exposed to infection are prevented from exposing others while infectious. Rates of infections are discussed at bimonthly staff and monthly quality meetings. Staff are made aware of new infections through daily handovers on each shift and progress notes.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	There is adequate human, physical and information resources to implement the infection control programme and meet the needs of the organisation. The infection control coordinator is the NM and has access to expert advice from the local DHB and the GP to achieve the requirements of this standard. Interviewed staff reported that they have adequate infection control resources to observe appropriate infection control measures.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of</p>	FA	There are documented policies and procedures for prevention and control of infection which comply with relevant legislation and current accepted good practice. The policies and procedures are practical, safe and appropriate for the type of service provided. The infection control policy and

<p>infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>procedures folders are accessible to all staff. The infection control job description is in place.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Relevant education on infection control is provided to all staff at orientation and annually. Infection control training records were sighted. In interview, the NM and CGs demonstrated knowledge on the infection control procedures. The ICC attends infection control trainings conducted by the DHB. Residents' education is provided in a manner they understand. External contact resources included: GP practice, laboratories and local district health boards.</p>
<p>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.</p>	<p>FA</p>	<p>Surveillance of infections is carried out according to the infection control programme. The ICC reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. All infections are recorded on the infection report form, this information is collated and reviewed and analysed by the ICC who will advise staff and management of the outcome.</p> <p>Analysis includes identifying trends and comparisons against the previous years. GP is notified if there is any resistance to antimicrobial agents and evidence of GP involvement and laboratory reporting was sighted. Surveillance programme is reviewed during the infection control programme review.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Interview with the nurse manager/restraint coordinator provides evidence that the homes restraint philosophy and practice is to maintain a restraint free environment. There have been no restraints used since 2016. The restraint register correctly recorded six residents using bed levers and transfer belts as enablers and eight residents requiring lap belts when in wheelchairs. The resident files reviewed confirmed these were voluntary and had been consented and agreed to by the residents using them.</p> <p>The restraint policy describes processes for assessment, consent and monitoring that would meet this standard when a restraint intervention is required. It contains definitions that are congruent with this standard and describes methods for avoiding or minimising the use of restraint. Policy</p>

		<p>designates a restraint coordinator, and clearly describes the processes for evaluation, review and ongoing staff education.</p> <p>Review of a sample of staff files and training documents confirmed that staff engage in ongoing education. This included managing challenging behaviour, use of de-escalation techniques and preventing the use of restraint. There is also an emergency restraint policy which authorises an RN to initiate an emergency restraint before a GP assessment.</p>
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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.

No data to display

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	CI	Consultation with residents and their families about food, fluids and the meals service, occurs frequently. This occurs via random meal audits, through surveys and at monthly resident meetings. Tarahill Rest home continues to serve its main meal at night because that is what residents prefer.	The efforts and attention to food and nutrition services in this home are a real feature. Resident and family feedback about meals and the quality of food services continues to receive 100% satisfaction. The service responds immediately to any resident's request for change.

End of the report.