

# G A & H J Lydford - Tarahill Resthome

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	G A & H J Lydford	
<b>Premises audited:</b>	Tarahill Resthome	
<b>Services audited:</b>	Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 5 November 2020	End date: 5 November 2020
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	17	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Tarahill Rest Home provides rest home level care for up to 18 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 certification audit in 2018.

This unannounced surveillance 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.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent. Resident records are maintained as required.

The complaints register reviewed showed no formal complaints received since 2018. Complaint policies and procedures meet requirements and contain a clear description of the processes to follow for effective management. Staff, residents and families interviewed were aware of the complaints process.

## 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.
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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.

## 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.		Standards applicable to this service fully attained.
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Residents are assessed prior to entry to the service to confirm their level of care. The process for assessment, planning, evaluation and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented and these are based on a comprehensive range of information and accommodate any new problems that might arise. All files reviewed demonstrated that the care provided, and needs of residents, are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP).

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. There is an approved food control plan in place.

## 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 has a current building warrant of fitness. There have been no changes to the structure of the building. All areas inspected were clean and in good repair.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Tarahill Rest Home has a philosophy and practice of no restraint. On the day of audit five residents were using bed levers and transfer belts as enablers 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.
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The infection prevention and control surveillance programme is appropriate to the size and scope of the service. The required data is collected, analysed and communicated.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	0	0	0	0
<b>Criteria</b>	0	41	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints register reviewed showed no formal complaints had been received since 2018. Any verbal concerns are dealt with as soon as they arise by the manager to achieve a satisfactory resolution and records are kept of these.</p> <p>The complaints policy and associated forms meet the requirements of this standard and Right 10 of the Code of Health and Disability Services Consumers rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed said they felt comfortable and would not hesitate to raise a concern if they had one. The director/nurse manager is responsible for complaints management and follow up. Each staff member interviewed confirmed a sound understanding of the complaint process and what actions are required of them.</p> <p>There have been no complaints to the Health and Disability Commissioner (HDC) nor any requests for advocacy services to provide support since the previous audit in 2018.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p>



<p>with consumers and provide an environment conducive to effective communication.</p>		<p>Staff know how to access interpreter services if required. Staff can provide interpretation as and when needed. The use of family members and communication cards is encouraged.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The 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 24 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 and respite care. There were no people under the age of 65 years staying in the facility nor any for respite/short stay care on the day of audit. On the day of audit 17 of the 18 beds were occupied.</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>	<p>FA</p>	<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. The family survey in June 2020 and the resident meal survey in September revealed no concerns and high satisfaction. 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 regularly. Staff confirmed their involvement in quality and risk management activities. The 2020 quality plan is goal focused. Actions taken and progress toward improvement is reported back to staff.</p> <p>Any service shortfalls identified via internal audits or feedback, are remedied by implementing corrective or preventative actions. These are also noted on incident forms. The staff interviewed said that information related to improvements required was communicated in writing or verbally at handover or meetings.</p> <p>Policies are based on best practice and are kept 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>All risks to the organisation, residents, staff and visitors are documented in policy, on the hazard register and in</p>

		<p>the risk plan with actions for mitigation. The directors are familiar with the Health and Safety at Work Act (2015) and its requirements. They described processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The nominated health and safety officer manages all 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>A sample of the 48 incident accident records from 2019 to date in 2020, 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. They advised there had been one Section 31 event notified to the Ministry of Health and the DHB in April 2020 which was related to a shortage in registered nurse (RN) hours. This has since been resolved by contracting another RN to be on site for eight hours a week.</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 providing services at the home 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. A new staff member who was orientating on the day of audit said the process was preparing 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 evacuation 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. Two of the nine carers have achieved level four (4) of the national certificate in health and wellness, two have completed level three (3) and the others had either previously completed studies related to care of older people or have started the national certificate. The staff records reviewed demonstrated attendance at ongoing training and completion of annual performance appraisals.</p>

		The nurse manager is trained and maintaining annual competency requirements to undertake interRAI assessments.
<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 members interviewed supported this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system is implemented to ensure that residents receive medicines in a safe and timely manner. Medications were stored in a safe and secure way in the trolley and locked cupboards. Medication reconciliation is conducted by the nurse manager and RN when the resident is transferred back to service from hospital, appointments, or when there are any medication changes. All medications were reviewed every three months and as required by the GP. Allergies were clearly indicated, and uploaded photos were current for easy identification.</p> <p>An annual medication competency is completed for all staff administering medication. The staff member observed administering medicines following the required medication protocol guidelines and legislative requirements. The controlled drug register is current and correct. Weekly and six-monthly stock takes were conducted. Monitoring of medicine fridge temperatures was conducted regularly and deviations from normal were reported and attended to promptly. All expired medications were returned to the pharmacy in a timely manner.</p> <p>There was one resident who was self-administering inhalers and was assessed as competent. A self-medication policy is in place. Medication administration records were maintained.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional</p>	FA	<p>Meal services are prepared on site and served in the allocated dining room. 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. The menu has been reviewed by the registered dietitian. There was a four-weekly rotating summer meal menu in place. Diets were modified as required and the cooks confirmed awareness on dietary needs of the residents. Meals were served warm in sizeable portions required by residents and any alternatives were offered as required. The residents' weights were monitored monthly and</p>

<p>needs are met where this service is a component of service delivery.</p>		<p>supplements were provided to residents with identified weight loss issues. The residents and family/whanau interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen was registered under the food control plan and the registration expires on 25 May 2021. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates were on all containers. Records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning was conducted.</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>	<p>FA</p>	<p>All care plans reviewed evidenced that interventions were adequate to address the identified needs in the care plans. Significant changes were reported in a timely manner and prescribed orders carried out. The nurse manager reported that the GPs' medical input was sought in a timely manner that medical orders were followed, and care was person centred. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The planned activities were appropriate to the residents' needs and abilities. The activities were based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Social and recreational assessments were completed within two weeks of admission in consultation with the family/whanau. The activities were conducted by the qualified DT with help from care staff during weekends. The DT in consultation with the nurse manager and were involved in developing a monthly planner which was posted on the notice boards and given to all residents. The activities were varied and appropriate for rest home level of care residents and were offered from Monday to Sunday.</p> <p>Residents' files had a documented activity care plan that reflected their preferred activities of choice and were evaluated every six months or as necessary. The residents were observed to be participating in a variety of activities on the audit day. The planned activities and community connections are suitable for the residents. During Covid-19 visiting restrictions family/whanau were either contacting residents through phone calls, skype and zoom and this was confirmed by residents and families in interviews conducted. There are regular outings/drives, for all residents (as appropriate). Family members interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service</p>	<p>FA</p>	<p>Resident care is documented on each shift by care staff in the progress notes. The nurse manager and RN document weekly or as necessary. All noted changes by the health care assistants were reported to the nursing staff in a timely manner.</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occurred every six months or as residents' needs change. These were carried out by the nurse manager in conjunction with family, GP and specialist service providers. Where progress was different from expected, the service responded by initiating changes to the service delivery plan.</p> <p>Short term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau were included and informed of all changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building warrant of fitness expires on 16 June 2021.</p> <p>Appropriate systems are in place to ensure the residents' physical environment, equipment and furniture is fit for their purpose and maintained. There have been no changes to the building structure. External areas are safely maintained and are appropriate to the resident group and setting. Trial fire evacuations are occurring six monthly.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed by the nurse manager to identify any significant trends or common possible causative factors and action plans were implemented. Staff interviewed reported that they were informed of infection rates at handovers, team meetings and through compiled reports.</p> <p>There was no infection outbreak since the previous audit. Covid-19 information is in place and all ministry of health (MOH) requirements were being followed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Tarahill Rest Home has a philosophy and practice of no restraint. Should restraint be required, the policies contain definitions which are congruent with this standard and describe processes for assessment, consent and monitoring. Policy designates a restraint coordinator, and clearly describes the processes for evaluation, review and ongoing staff education. The restraint register recorded five residents using bed levers and transfer belts as enablers. The resident files reviewed confirmed these were voluntary and had been consented and agreed to by the residents using them.</p> <p>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</p>

		RN to initiate an emergency restraint before a GP assessment.
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## Specific results for criterion where corrective actions are required

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

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

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

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

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End of the report.