

Y&P NZ Limited - Deverton House Rest Home

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 The DAA Group 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:	Y&P NZ Limited
Premises audited:	Deverton House Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 April 2021 End date: 23 April 2021
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:	21

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
	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

Deverton House Rest Home (Deverton House) provides rest home level care for up to 23 residents. The service is operated by a private owner/director and it is one of four facilities owned by the same operator. Deverton House is managed by a facility manager who is supported by two registered nurses who oversee the clinical service. Residents and families spoke highly about the care and management provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family, the facility manager, owner/director, staff and a general practitioner.

There were no new areas requiring improvement. The one area identified from the previous audit in relation to medicines management has been fully addressed.

The two rooms reconfigured since the previous audit and already approved for use are occupied and are appropriate for occupancy. Both rooms were occupied at the time 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.

Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreting services if required.

A complaints register is maintained with complaints resolved in a timely manner 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.

Business and quality and risk management plans are documented and clearly describe the scope, direction, objectives and the mission statement of the organisation.

Monitoring of the services occurs and outcomes are reported to the owner director on a daily and/or monthly basis. Any trends identified are used for quality improvement. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks are identified and mitigated. Newly implemented policies and procedures support service delivery.

The appointment, orientation/induction and management of staff both clinical and non-clinical is based on current good practice. Training is provided and is ongoing. Staff appraisals were up-to-date.

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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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. 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 planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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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There was a current building warrant of fitness publicly displayed.

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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The organisation has implemented a non-restraint policy as described in their policies and procedures. No enablers and no restraint were in use at the time of the audit.

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 programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	16	0	0	0	0	0
Criteria	0	39	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to all residents and families on admission and those interviewed knew how to do so and where to locate the complaints form at reception. This is documented in both English and Chinese version on the one form.</p> <p>The complaints register reviewed showed that four minor complaints have been received in the last twelve months and all have been addressed and signed off by the facility manager and dated. The facility manager is responsible for the complaint management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of medical reviews. This was supported in residents' records reviewed. Staff interviewed understood the principles of open disclosure which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>All staff on duty spoke English on the day of the audit. Staff know how to access formal interpreter services</p>

conducive to effective communication.		through the district health board although reported this rarely occurred. Staff are able to provide interpretation as and when needed and family members are used when required.
<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>	FA	<p>The Deverton House Rest Home Business Plan which is reviewed annually was available. The business plan outlines the purpose, values, scope, direction and objectives of the organisation. The document describes the annual goals, strengths and challenges and associated operational plans. The mission statement and philosophy are implemented for residents and for staff and is a guide to achieving the philosophy. There is a staff philosophy documented as well. Objectives, goals, care, professionalism and education goals are outlined for staff to achieve. There is an organisational commitment to staff training and the programme was reviewed for 2021. A sample of monthly reports from the registered nurses was sighted. The facility manager who has worked in this role for four years reports directly to the owner/director on a regular basis. Any emerging risks and/or issues are reported on a daily basis.</p> <p>The care service is managed by two registered nurses who cover twenty hours a week at this facility. There is a casual registered nurse who can cover in either of their absence, to ensure these hours are provided weekly. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. Members of the management team confirm their knowledge of the sector. The owner/director was contacted and was present during most of the audit process.</p> <p>The service holds a contract with Waitemata District Health Board (WDHB) for rest home level care including respite care. Twenty one of the twenty three beds were occupied and the 21 residents were receiving rest home level care services under the Age Related Residential Care contract at the time of the audit.</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>The organisation has a planned quality and risk system that reflects the principles of continuous improvement. The quality plan was reviewed for 2021 to 2022. This includes management of incidents and complaints, audit activities, a regular resident satisfaction survey, monitoring of outcomes and clinical incidents including infections. The business continuity and risk management plan was developed to guide staff and management in managing emergencies and this has been reviewed for 2021 – 2022.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management, staff and resident meetings as appropriate. The facility manager reports to the owner/director monthly. The owner director has four aged care facilities so moves between the four on a regular basis and is always available to the facility manager as needed and for families and residents. Staff interviewed are involved in audit activities, review of quality and clinical data. Corrective action follow-up is implemented to address any shortfalls with the outcomes evaluated prior to sign off.</p> <p>Resident and family satisfaction surveys are completed annually - last completed 4 August 2020. Sixteen of</p>

		<p>twenty three survey forms were completed; three residents refused to complete the form and four found it hard to comprehend the questions. The survey results reviewed showed that residents and families are very satisfied with services provided. Any comments made have been followed up by management.</p> <p>One year ago, the policies and procedures were changed over to another hard copy system and are fully managed and implemented by a quality consultant. Staff have received training on the new policies and procedures for the organisation. They are based on best practice and were current. The documentation control and review system is set up and functioning effectively. Removal of all obsolete documents has occurred. 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.</p> <p>The facility manager understands the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager and owner director interviewed was fully informed with the Health and Safety at Work Act (2015) and has implemented requirements.</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 and near miss events on an accident/incident form. Individual incident logs are maintained in each resident's individual record reviewed. A sample of incidents forms showed these were fully completed, incidents investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the facility manager.</p> <p>The facility manager described essential notification reporting requirements, including for any pressure injuries. They advised there has been one notification made to HealthCERT for a pressure injury. The resident transferred from the DHB to a private hospital. There have been no police investigations, coroner's inquests, issues-based audits and any other notifications 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</p>	FA	<p>Human resources management policies and processes are based on good employment practice and meet relevant legislation. The employment process includes referee checks, police vetting and validation of health professionals annual practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies and processes are consistently implemented and records are maintained.</p> <p>Staff are provided with orientation which includes all necessary components relevant to the role they are employed for. Staff interviewed stated that they were well prepared for their role. The staff records reviewed showed documentation of completed orientation/induction and a performance review after three months and annually thereafter. Appraisals for staff, clinical and/or non-clinical, were up to date except for one staff member.</p> <p>Education is planned on an annual basis including all mandatory training requirements. The training programme</p>

legislation.		is available to all staff. The eight care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Four care staff have completed New Zealand Qualifications Authority (NZQA) qualifications at level 4, three at level 1 and one care staff has not undertaken a course as yet. Competencies have been completed for this year for all staff.
<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 process for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of the residents. An after-hours roster is in place with staff reporting that good access to advice is available from the registered nurses or from the facility manager if it is a non-clinical issue. Resident and families supported this at interview. No agency staff are used at this facility. The care staff interviewed stated that they were able to complete the work on each shift allocated to them.</p> <p>Four weeks of rosters were reviewed. There are two registered nurses who cover twenty total hours a week. The registered nurse hours currently meet the requirements and acuity of the residents. A casual back up registered nurse is available if needed and one caregiver is on the casual pool. At least one staff member is on duty that has completed a first aid certificate.</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 policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates.</p> <p>No controlled drugs (CD) were stored onsite on the day of audit. No residents were prescribed any controlled drugs. Facilities are available to store CDs securely in accordance with requirements and these are checked by two staff for accuracy when administering, when in use. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries, while they were in use.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three</p>

		<p>monthly GP review was consistently recorded on the medicine chart. Standing orders were not used. Drug allergies were clearly recorded on the medication chart.</p> <p>At the time of audit, none of the residents were self-medicating. Staff understand the appropriate processes to ensure this is managed in a safe manner when required.</p> <p>There is an implemented process for comprehensive analysis of any medication errors. The area identified for improvement at the previous audit has been addressed.</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>	FA	<p>The food service is provided on site by a kitchen team consisting of two cooks and two kitchen hands, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Auckland Council in March 2021. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Cooks have undertaken a safe food handling qualification, with kitchen hands completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of high standards. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was 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>	FA	<p>The activities programme is provided by the activities coordinator. Two staff are currently training to be registered diversional therapists. A wide range of activities are provided seven days a week.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated as part of the formal six monthly care plan review.</p> <p>The weekly activities planner sighted matches the skills, likes, dislikes and interests identified in the assessments. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings. Residents interviewed confirmed they enjoy the programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for bruises and pain management. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting 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>	FA	<p>A current building warrant of fitness, expiry date 27 July 2021, was publicly displayed. The two additional single residents' rooms were reconfigured since the previous audit and both rooms are occupied. The rooms are close to bathroom facilities and both rooms are decorated to meet the needs of the individual residents. These two rooms are situated close to the reception and nurse's office, lounge and entrance to the facility. No change to the fire evacuation plan was needed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, chest, eye and wound. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early</p>

is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		<p>intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Infection rates remained low and the trends were discussed during the staff meetings and management meetings.</p> <p>Covid-19 pandemic preparedness document was sighted and staff interviewed were aware of the plan.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. An experienced registered nurse is the restraint coordinator. On the day of the audit the facility was restraint free, and no enablers were in use. Staff interviewed understood the difference between an enabler and a restraint. Policy identifies an enabler to be the least restrictive and used voluntarily at the resident's request. Restraint is only used as a last resort when all alternatives have been explored.</p>

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.

No data to display

End of the report.