

# Tasman Rest Home and Dementia Care Limited

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Tasman Rest Home and Dementia Care Limited
<b>Premises audited:</b>	Tasman Rest Home & Dementia Care
<b>Services audited:</b>	Hospital services - Psychogeriatric services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 18 November 2014    End date: 19 November 2014
<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>	48

# 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
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

Tasman Rest Home and Dementia Care provides dedicated dementia rest home level care for up to 26 residents in two small homes, psychogeriatric care for up to 12 residents in one small home and rest home and hospital level care for up to 15 residents. On the day of audit there were 48 residents, 12 in Ata (dementia care), 12 in Rangī (dementia care), nine in the psychogeriatric unit and seven hospital residents and eight rest home residents in the rest home/hospital.

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings. The service continues to maintain a continued improvement focus since previous audit. A number of education initiatives are implemented at Tasman including specialist dementia training for staff and families.

The operations manager is an experienced manager and has been in the role for two years and 10 months. She has worked in disability management roles for 7.5 years prior to this. The clinical manager (has been in the role since March 2013) provides clinical oversight. They are supported by a stable staff and the management team at Dementia Care NZ.

This audit has identified one area for improvement around the roster. The service is commended for achieving six continual improvement ratings relating to family information and support, good practice, quality goals and quality initiatives and implementation of a comprehensive education programme.

## 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.

All standards applicable to this service fully attained with some standards exceeded.

Tasman Rest Home and Dementia Care strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. Complaints processes are implemented and complaints and concerns are actively managed and well documented. A complaints register is maintained. The service has areas of excellence around family information and education and good practice.

## 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.

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

Dementia Care NZ Ltd (DCNZ) is the parent company of Tasman Dementia Care. The operations manager of Tasman reports to the DCNZ Operational governance group on a monthly basis. Against the quality and risk management plan and also the vision and values which are embedded into practice. The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and other staff meetings. The service is active in analysing data and comprehensive reports, trends and action plans are completed. Corrective actions are identified and implemented and shows follow up and review. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status.

Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. Friends and family satisfaction surveys are completed and regular resident/relative meetings are held.

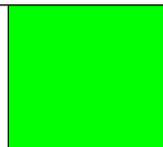
There are comprehensive policies/procedures to provide hospital and dementia specific care. There are appropriate clinical procedures for the introduction of hospital residents. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers relevant aspects of care and support. The training programme for staff also includes specific training based around the services, "Best Friends Approach to Dementia Care" (putting yourself in their shoes). This is carried out for all staff regularly and is key to living their values and philosophy.

Families are provided with two programmes called 'sharing the journey' and 'orientation for families'. These provide information and support for family members in understanding dementia. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

The service has areas of excellence around staff training, governance and the quality improvement programme.

## 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.

There are pre-entry and admission procedures in place. The service is pro-active in the community and meets with external groups. There is a well presented information booklet for residents/families/whanau at entry that includes information on the service philosophy and practices particular to the secure units. Care plans are developed by the services registered nurses and are reviewed six monthly in the facility. Families are involved in the development and review of the care plan. A multi-disciplinary meeting occurs six monthly. The service has strong vision that is reflected in a team approach with a comprehensive mentoring programme that assists with support and values.

All staff are qualified in their roles and complete on-going training around the specific needs of people with dementia. All assessments linked into the comprehensive care plan.

Care plans are individually developed, holistic and meet resident's needs. Other specific needs of residents such as medical conditions are included. There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes.

There is a planned seven days activities programme that is developed by recreation staff and daily household activities are completed. They are supported by an organisational wellness support coordinator that supports the team and monthly teleconferences are provided.

The medication management system includes medication policy and procedures and there is on-going education and training of staff in relation to medicine management.

The main kitchen provides food to each unit. The service also has access to a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files.

## 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.

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness displayed in the foyer. Residents were able to move freely inside and within the secure outside environments off the dementia units.

Tasman is divided into small homes. Their philosophy of the 'small homes' means that the environment feels more home-like, and residents orientate to their environment more easily. Each home is well maintained with easy access to the secure gardens and paths.

Each small home has their own dining/lounge areas. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. Communal service areas are separate and activities can occur in the lounges and/or the dining area. The service has in place policies and procedures for effective management of laundry and cleaning practices. The service has implemented policies and procedures for civil defence and other emergencies. There is staff on duty with a current first aid certificate. Fire drills are conducted six monthly and the fire service has approved the evacuation scheme. General living areas and resident rooms are appropriately heated and ventilated

## 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.

There is a restraint minimisation and safe practice policy and procedure applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint training is provided at orientation and is completed as part of the services annual training schedule. This includes restraint a self-directed learning and competency for restraint minimisation. Individual restraint interventions are evaluated monthly and documented in the care plan and on the restraint register. There are four residents on the register assessed as requiring intermittent restraint (three 'arm restraints' and one resident with T belt). The register shows a monthly review by the restraint coordinator and the register is updated each month. There is a robust restraint approval group and process in place that meet six monthly. The restraint approval group also includes a consumer representative and the service is focused on minimising restraint.

## 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 management systems are well documented and implemented to minimize the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality and risk management plan. There is a comprehensive orientation and education programme for all staff.

Infection rates are monitored and benchmarked with other facilities within the organisation. Benchmarking also occurs with other facilities within the organisation and the results are used to identify any shortfalls in care services and infection control and set quality improvements.

## 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>	4	45	0	1	0	0	0
<b>Criteria</b>	6	94	0	1	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>There is a code of rights policy and procedures in place. The code of health and disability rights is incorporated into care. Discussions with six caregivers (the home manager from each unit, one who works in the rest home/hospital and one who works across all services) identified their familiarity with the code of rights. A review of care plans, meetings and discussion with 10 family members (three from the dementia unit, four from the psychogeriatric unit, one from the rest home and two from the hospital) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided on the code of rights and advocacy in October 2014. Code of rights is also included in the orientation training session and package for new staff. Additionally all staff have completed a competency assessment on advocacy and code of rights.</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</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification</p>

<p>choices and give informed consent.</p>		<p>and social display and consent for outings. Residents have a medical guidance plan that covers admission to hospital and resuscitation. There is evidence of resident/EPOA/GP and clinical manager participation in the medical guidance plan.</p> <p>Tasman's philosophy includes an emphasis on getting to know the resident, spending time with them and treating them as if they were your "best friend". Interviews with staff and families supported that they have input and are given choices. Care plans and 24 hours multidisciplinary care plans demonstrate resident choice as appropriate.</p> <p>D13.1 There were eight admission agreements sighted and these had been signed on the day of admission</p> <p>D3.1.d Discussion with six families (three dementia, one rest home and two hospital) identified that the service actively involves them in decisions that affect their relative's lives.</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>	<p>FA</p>	<p>The right to access advocacy services is identified for residents/families. There is an advocacy and consumer support policy in place. Leaflets are available at the entrance. The information identifies who to contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. An independent advocate visits monthly. There is an identified family support person and advocate who visits residents weekly.</p> <p>Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed.</p> <p>D4.1d; Six family members interviewed (three from the dementia unit, one from the rest home and two from the hospital) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.</p> <p>ARHSS D4.1f: The two psychogeriatric resident files include information on resident's family/whanau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other</p>	<p>CI</p>	<p>D3.1h; ARHSS D16.5f: All relatives interviewed stated they could visit at</p>

<p>Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>		<p>any time and that they are encouraged to be involved with the service and care. Visitors were observed coming and going during the audit. Visiting is actively encouraged.</p> <p>D3.1.e Interviews with the wellness support advisor and three activities staff described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping. Entertainers are included in the hospital/dementia units' activities programme. The activities coordinators described how outings in the van are tailored to meet the interests of the residents. Residents are encouraged to maintain outside interests as appropriate. Assistance with transport is provided as required.</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>	<p>FA</p>	<p>The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. D13.3h, ARHSS D13.3g: Complaints information is available in each unit and information is provided to residents and relatives at entry.</p> <p>There is an established and up to date complaints register that is also included on an access database format. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response. Specific QIs are raised from complaints. For 2014 (to date) there have been three written complaints including one from a DHB allied health professional. The complaints were all well documented and managed.</p> <p>E4.1biii. There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none"> <li>1. Minimising restraint.</li> <li>2. Behaviour management.</li> </ol>

		3. Complaint policy.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	<p>The service provides information to residents, families, next of kin and/or EPOA. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. On entry to the service, the clinical manager or registered nurse discusses the information pack with the resident and their family/whanau. This includes the code of rights, complaints and advocacy information. Discussions with 10 family members identified they are well informed about the code of rights.</p> <p>There is an orientation for families course is provided on admission; this is voluntary for new families of residents to assist them with the transition into care. The orientation informs the family about dementia care provided at Tasman.</p> <p>D6,2 and D16.1b.iiiThe information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health and Disability Commission.</p> <p>Resident/family right to access advocacy and services is identified and advocacy service leaflets are available at the entrance. Information provided prior to entry provides them and their family/whānau with advocacy information. This includes details of the national and local advocacy services. There is an identified family support person and advocate who visits residents weekly. Discussions with six caregivers identified they are aware of the right for advocacy and how to access and provide advocacy information to residents if needed.</p>
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	<p>The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident information and employment agreements bind staff to retaining confidentiality of client information.</p> <p>Discussions with 10 family members identified that personal belongings are not used as communal property.</p> <p>During the visit, staff demonstrated gaining permission prior to entering</p>

		<p>resident private areas. Interviews with family members and residents identified that caregivers always respect residents' privacy.</p> <p>Resident files are held in locked nurses' offices or in locked filing cabinets.</p> <p>D3.1b, d, f, i The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality</p> <p>D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.</p> <p>E4.1a Three families of residents in the dementia unit state that their family member was welcomed into the unit and personal pictures were put up to assist them to orientate to their new environment.</p> <p>Tasman's aims to achieve it's vision by promoting the uniqueness of each person, the immense value of each person and by promoting openness, honesty and integrity.' Residents' support needs are assessed using a holistic approach. Assessments are incorporated into a care plan which includes a section on expressing spirituality and culture. The service has developed and implements an intercultural awareness training programme for staff.</p> <p>All 10 family members interviewed confirmed that the service is respectful and responsive to the resident's needs, values and beliefs. Single rooms are provided.</p> <p>There is an abuse and neglect policy that includes definitions and examples of abuse. Staff could describe definitions. Discussions with six registered nurses, the clinical manager, and six caregivers identify that there is a strong culture of reporting. Relatives interviewed said that the care provided is very good. Abuse and neglect training was last delivered in August 2014 by an external advocacy group.</p> <p>ARHSS D4.1b Two psychogeriatric resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.</p>
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<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>The service gathers appropriate spiritual, religious and cultural information that is relevant and sufficient to support an appropriate response to the needs of residents. There is one Maori resident that does not have any specific cultural needs or affiliation. Planning is done in conjunction with the resident/family. The service's philosophy of care results in each person's cultural needs being considered individually. External specialist advice is sought as necessary.</p> <p>There are current guidelines for the provision of culturally safe care for Māori residents. Discussions with staff indicate that they have an awareness of the need to respond appropriately to the cultural values and beliefs of Māori. Staff make every effort to assist residents to practice their cultural values. Special events and occasions are celebrated at Tasman. There is currently one resident of Maori ethnicity but this resident chooses not to identify with her culture as confirmed by her whanau.</p> <p>Family/whanau involvement is actively encouraged through all stages of service delivery. Whanau are invited to attend residents' reviews. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau.</p> <p>A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)</p> <p>D20.1i The service has established a local contact who is Māori and is available for advice as required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service establishes links with family/whanau or other appropriate representatives as required. Family meetings occur at admission, and at multi-disciplinary team meetings. Management or a registered nurse contacts family when required. Family members confirm they are consulted regarding individual values and beliefs.</p> <p>D3.1g The service provides a culturally safe service by implementing Tasman's vision and values of care and service which promotes the uniqueness of the individual and provides opportunities to enrich the lives of each resident. During the admission process, the registered nurse along with the family/whanau completes the documentation. The</p>

		<p>assessment process and philosophy of care enables appropriate responses to individual cultural beliefs. Initial and on-going assessment includes gaining details of people's culture, beliefs and values.</p> <p>D4.1c There is a section around expressing spirituality and culture in the care plan.</p> <p>Families are actively encouraged to be involved in their relative's care in whatever way they want. The service provides an Intercultural Awareness education programme for staff that was developed in partnership with the Office of Ethnic Affairs using their in-house intercultural course contextualised by the service to suit the aged care sector. Cultural safety is part of the orientation training and competency package.</p> <p>ARHSS D4.1d: Two psychogeriatric care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There are policies which include discrimination and professional boundaries. These are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. Qualified staff are, in addition, required to abide by a professional code of ethics. The code of conduct discusses consequences if the code of conduct is not followed.</p> <p>Discussion with the operations manager and a review of complaints identified no complaints of discrimination, coercion or exploitation of residents.</p> <p>Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment. Performance appraisals are conducted and staff receive supervision. Discussions with 10 families identify that privacy is ensured.</p> <p>Discussions with caregivers described how professional boundaries are maintained.</p> <p>ARHSS D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with two psychogeriatric caregivers could describe how they build a supportive relationship with each resident. Interviews with four families</p>

		from the psychogeriatric unit confirmed the staff assist to relieve anxiety.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, health and safety meetings, staff appraisals, satisfaction surveys, education and competencies, complaints and incident management.</p> <p>At service level incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including on-going review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting. There are a number of quality improvement projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities.</p> <p>The annual education programme is comprehensive and includes programmes designed and implemented by the service: "best friends" is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular "Best Friends Approach to Dementia Care" (putting yourself in their shoes) training is carried out for all staff regularly and this is key to living their values and philosophy.</p> <p>Tasman is divided into four small homes. The small homes mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel. The smaller homes also have a higher staff ratio.</p> <p>The service is commended for maintaining good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is an open disclosure policy, a complaints policy and an incident/accident reporting policy. Family members stated they and the resident were welcomed on entry and were given time and explanation</p>

<p>provide an environment conducive to effective communication.</p>	<p>about services and procedures. Resident meetings occur monthly in each dementia unit (home) and in the rest home/hospital. Residents are encouraged to attend and to comment on the questions asked.</p> <p>A family focus meeting is held annually and is chaired by a director. Staff do not attend this meeting as it provides opportunities for residents/families to talk openly and freely. Outcomes of this meeting are fed back the operations manager and any issues that arise are dealt with through the quality improvement programme. The clinical manager and the operations manager have an open-door policy.</p> <p>Incident forms have a section to indicate if family have been informed (or not) of an incident/accident. Fourteen incident/accident forms were reviewed for November 2014. In all 14 forms reviewed, contact with families after an incident/accident is documented on the incident forms and in the progress notes.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term residential care in a rest home or hospital – what you need to know” is provided to residents on entry.</p> <p>D16.1b.ii Residents/family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement.</p> <p>D16.4b Six family members interviewed (three from the dementia unit, one from the rest home and two from the hospital) stated that they are always informed when their family member's health status changes or of any other issues arising.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents.</p> <p>The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whanau have difficulty with written or spoken English that the interpreter services are made available.</p> <p>ARHSS D16.1bii; The information pack and admission agreement included payment for items not included in the services. A site specific</p>
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		<p>Introduction to Tasman Rest Home booklet provides information for family, friends and visitors visiting the facility is included in the enquiry pack along with a new resident's handbook providing practical information for residents and their families.</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>CI</p>	<p>Tasman Dementia Care provides dedicated dementia rest home level care for up to 26 residents in two small homes, psychogeriatric care for up to 12 residents in one small home and rest home and hospital level care for up to 15 residents. On the day of audit, there were 48 residents: 12 in Ata Hapara (dementia care), 12 in Rangi (dementia care), nine in the psychogeriatric unit and seven hospital residents and eight rest home residents in the rest home/hospital.</p> <p>Dementia Care NZ is the parent company for Tasman Dementia Care and has a current charter and business plan and a quality and risk organisational plan that aligns with the business plan. The vision and values statement sets out the philosophy of the providers. Tasman Rest Home holds regular meetings including (but not limited to); quality, infection control, health and safety and resident/family meetings. The operations manager of Tasman reports to the director-general manager on a range of issues on a daily basis. The service is managed by an operations manager who is supported by a team of experienced staff - clinical manager, registered nurses, caregivers and the management team of Dementia Care NZ.</p> <p>D17.4b (hospital), The operations manager is an experienced manager and has been in the role for two years and 10 months. She has worked in disability management roles for 7.5 years prior to this. The clinical manager (has been in the role since March 2013) provides clinical oversight. The organisation provides training days with the clinical managers and senior management team to ensure at least eight hours annually of professional development activities occurs including those related to managing a hospital.</p> <p>ARC E2.1, ARHSS D5.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.</p>

		The service is commended for the implementation of the organisation vision, values, goals and objectives including (but not limited to) promoting independence and valuing the lives of residents and staff.
<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>During a temporary absence of the operations manager, the clinical manager assumes the role.</p> <p>D19.1a: A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, quality improvement (QI) programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.</p> <p>ARHSS D4.1a: The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life.</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>	CI	<p>DCNZ has a strategic business plan and a quality and risk management plan that are implemented and managed at service level by a quality services manager and quality team. There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through monthly quality meetings, monthly registered nurse meetings, monthly health and safety meetings, monthly infection control meetings and monthly reports to the directors.</p> <p>The quality committee meeting has a set agenda that includes all required areas. Minutes are maintained and easily available to staff in a folder. Minutes include actions to achieve compliance where relevant. Benchmarking is used as a means of identifying trends and potential risks or for advanced planning. This, together with comprehensive staff training, demonstrates the organisations and Tasman's commitment to on-going quality improvement.</p> <p>D5.4 The service has policies/ procedures to support service delivery. There is a document and data control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.</p>

	<p>The service collects information on resident incidents and accidents as well as staff incidents/accidents. Results are discussed with staff through the monthly meetings and the operations manager's monthly report to the DCNZ Operational Governance Group. There is evidence that complaints/concerns are followed up and any concerns raised through resident meetings, family focus meeting, and friends and family surveys are followed up and actioned. Infection control data is collated monthly and reported. Actual and potential risks are identified and corrective actions initiated. This is discussed at the monthly meetings and reported to the DCNZ Clinical Governance Group in the clinical manager's monthly report. Restraint is reviewed at the monthly quality meetings and at the six monthly restraint approval committee.</p> <p>Corrective actions are established as a result of internal audits, incidents, accidents, complaints and concerns. Corrective actions are discussed quality meetings. Meeting minutes are documented using a corrective action format. There is a detailed monthly newsletter to all staff that includes all quality data and any actions required, internal audit results, satisfaction survey results and any quality improvement plans. Discussions with the staff described that corrective actions are implemented. Internal audits are completed. Corrective actions identify the actions required; the person responsible, documentation of actions completed and signed completion. The QI log identified new quality initiatives.</p> <p>D19.3 There are implemented risk management and health and safety policies and procedures in place including incident/accident and hazard management. The health and safety policies include (but are not limited to): hazard identification; hazard management; staff responsibilities; employee participation in health and safety systems. There is a hazard register that is reviewed annually. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate.</p> <p>The monthly health and safety meetings identify actual and potential risks and corrective actions are initiated. There is a safe work booklet introduced for staff.</p> <p>D19.2g Falls prevention strategies are in place that include: assessment of risk, medication review, bone health introducing vitamin D, vision and hearing assessments, mobility assessments with physiotherapy input,</p>
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		<p>exercises/physical activities, training for staff on detection of falls risk, and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>D19.3d The service is aware that they will inform the DHB of any serious accidents or incidents. Discussions with management confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required.</p> <p>A review of 14 incident forms identified they were all fully completed and followed up appropriately by the RN including completing neuro observations for two residents, when the residents fell and hit their head.</p> <p>Minutes of the monthly quality meetings, registered nurse and the monthly staff bulletin reflect a discussion of incidents/accidents and actions taken. Benchmarking includes an analysis. The service analyses the trends and a comprehensive report is completed that includes outcomes and further actions required at a facility and organisational level. A regular review is completed of frequent falls (link 1.2.3.6).</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Tasman employs a total of 47 staff. There are job descriptions available for all positions and staff have employment contracts.</p> <p>Eight staff files were reviewed. Performance appraisals are up to date.</p> <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates sighted for all registered nurses, and allied/medical staff.</p> <p>There are comprehensive human resources manual which includes</p>

		<p>policies around recruitment, selection, orientation and staff training and development. Seven staff files were reviewed. Reference checks are completed before employment is offered and are evident in the staff files reviewed.</p> <p>There is an orientation programme and packages for all roles. All files reviewed showed evidence of orientation to roles with competency packages completed. The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.</p> <p>The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Twelve caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>There are competency packages for registered nurses and another for caregivers that cover all required competencies.</p> <p>The education coordinator manages a spread sheet of all staff and records all completed orientations, competencies and education attended.</p> <p>There are 34 caregivers employed in Tasman that work in the dementia unit. Twenty two have completed the required dementia standards, and eleven caregivers who have been in the service less than one year are in the process of completing. One caregiver employed the week before the audit is enrolled to commence the programme. There is an in-service calendar completed for 2013 and currently being implemented for 2014. The annual training programme well exceeds eight hours annually.</p> <p>ARHSS D17.7 The diversional therapists working across the special care unit have completed dementia training.</p> <p>The service is commended for the number of quality initiatives based around education of staff and relatives.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from</p>	<p>PA Low</p>	<p>The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Rosters are in</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>place and show staff coverage across the dementia unit, the psychiatric unit and the rest home/hospital. The psychogeriatric unit and rest home hospital are in the same building in very close proximity.</p> <p>At an organisational level there is a regional clinical manager that provides clinical support and leadership. Allied health professionals are accessed on an as required basis.</p> <p>Interviews with family members, residents and staff confirmed that staffing levels are good across each area.</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>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in offices. Resident records are kept up to date and reflect residents' current overall health and care status. Records can be accessed appropriately by staff.</p> <p>D7.1 Entries are legible, dated and signed by the relevant staff member including designation.</p> <p>Individual resident files demonstrate service integration. This includes medical care interventions and records of the diversional therapist. Medication charts are in a separate folder.</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>	<p>FA</p>	<p>There are pre-entry and admission procedures in place. Residents are assessed on entry to the service and needs assessments are sighted on the eight resident files sampled. The service liaises with assessment services and service coordinators as required. The service has a well presented information booklet for residents/families/whanau at entry. It is comprehensive and designed so it can be read with ease (spaced and larger print).</p> <p>E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c)</p>

		<p>specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none"> <li>1. Minimising restraint.</li> <li>2. Behaviour management.</li> <li>3. Complaint policy.</li> </ol> <p>D13.3 The admission agreement reviewed aligns with a) -k) of the ARC contract</p> <p>D14.1 Exclusions from the service are included in the admission agreement.</p> <p>D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p> <p>E3.1 Two files for residents in the dementia units were reviewed and all includes a needs assessment as requiring specialist dementia care.</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>	<p>FA</p>	<p>There is a discharge planning and transfer policy and resident transfer to hospital (acute) policies to guide staff in this process. Discussions with the service confirm that resident exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of residents care through the completed transfer form, copy of relevant progress notes, copy of medication chart and doctor's notes. A staff member or family member accompanies dementia care residents to the hospital. Discussions with the RN's and clinical manager confirm that resident exit from the service is co-ordinated and planned and relevant people are informed. There is a verbal handover where required to new service providers to ensure continuity of residents care</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>	<p>FA</p>	<p>The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice. The service uses robotic system for regular medication and blister packs for PRN medications. The RN checks these on arrival from the supplying pharmacy. The pharmacy is available after hours to the service for urgent requests. Medication</p>

		<p>reconciliation is implemented via the 'medication management on admission and transfer policy' .RN's and caregivers administer medications. Orientation to medications includes a self-learning package and supervised medication rounds. Annual competency and medication education has been completed August 2014. The medication folder contains standing orders, medication information folder on common medications, MOH medication guidelines and nutritional supplements list.</p> <p>Medication trolleys and locked medication storage areas are located in both the Hospital unit and the rest home dementia unit. Staff attended End of Life care education in July 2014. There are adequate pharmaceutical and medical supplies sighted. Eye drops are dated when opened. Medication expiry dates are checked fortnightly. The hospital medication fridge is monitored daily and within acceptable parameters.</p> <p>Seventeen medication charts (minimum of four from each unit) reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. GP prescribing meets the legislative requirements.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b> A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a kitchen service manual located in the kitchen which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. The main kitchen provides food to the kitchenettes in each unit. Food is transported by hot boxes. Temperature checks are undertaken daily for the fridges, freezers, sanitizer, and hot foods at each meal time. Food in the pantry is stored off the floor and stock is rotated each week when the food order is delivered. Perishable food is covered and dated in the fridges. The cooks have undertaken food safety and hygiene training. Food safety competencies are also completed. There is an evening meal assistant. There is a four weekly menu in place. An organisational food services management consultant reviews and advises on menus 24 monthly and more often if necessary. The service also has access to a Dietician monthly for review of resident needs. A resident dietary profile is undertaken on each resident on admission and a copy provided to the cook and updated as required by the RN's. Special diets (eg. gluten-free), meal textures, likes and dislikes are known and catered for. Changes to residents' dietary needs are communicated to the kitchen.</p>

		<p>Monthly weights are completed and where there is an issue this is addressed through the care planning process and communicated to the cooks. Special equipment is available as required such as lipped plates. Care plans include clear instructions for nutrition needs across the 24 hours. Nutrition and hydration is identified as a component of the care plan and these were noted in the eight resident files sampled (two hospital, two rest home, two psychogeriatric and two rest home dementia).</p> <p>Feedback on the food service is received through staff and resident meetings. The cooks meet with management regularly. Kitchen service audits are undertaken and recently have 100% compliance.</p> <p>Meals viewed in units noted that food services and the staff serving made efforts to provide meals that resident would eat.</p> <p>E3.3f: There is evidence that there are additional nutritious snacks available over 24 hours.</p> <p>D19.2 Staff have been trained in safe food handling.</p>
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></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>FA</p>	<p>The reason for declining service entry to residents is recorded should this occur and communicated to the resident/family/whanau. Staff report that the referring coordinator would be advised when a resident is declined access to the service and it is then their responsibility to inform the resident/family/whanau of other options that may assist them to meet their needs.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>ARC E4.2; ARHSS D16.5gii Resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.</p> <p>E4, 2a Challenging behaviours assessments are completed.</p> <p>The information gathered at admission is used to set care plan goals and objectives for residents. The admission health assessment form provides a comprehensive assessment on admission and is used to develop the care plan goals and objectives. There is an on-going assessment of</p>

		<p>resident's policy that includes assessments that should be in place and timeframes. RN's complete initial assessments within 24 hours of admission.</p> <p>A range of assessment tools are completed on admission and reviewed at least six monthly as applicable and include (but not limited to); continence assessment, falls risk, Braden pressure area tool, wound, nutritional screening, activity initial assessment , and pain assessment tools. There are other allied health assessments completed such as dietitian assessment and physio assessment. The diversional therapist also completes a comprehensive social assessment. Assessments are conducted at the facility in agreement with the resident/family member or EPOA. Residents have private rooms where they can be assessed</p> <p>Frequent falls physiotherapy assessments are carried out as required. Falls risk and interventions are well documented in care plans that include the use of sensor mats and hip protectors. Challenging behaviour assessments are well documented with excellent follow up into care plans for the care files sampled. Behaviour monitoring forms are used to record behavioural or disruptive actions and describe distraction techniques. Wandering resident and identification form is included in the resident files as needed.</p> <p>E4.2; Two resident files from the dementia unit reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans are developed and reviewed by the RN's. The care plan plans are holistic, comprehensive and meets residents needs and includes diagnosis/needs, aim and action. The first page of the long term care plan includes the name and signature of the resident/family member who has participated in the development (D16.3f; ARHSS D16.5f). The long term care plan describes needs for all domains. A 24 hour MDT (multidisciplinary) care plan is completed by the DT and RN. The MDT care plan details the residents morning and afternoon habits, behaviours, activities or diversions that work, nocte pattern, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation. The diversional therapist or family complete a resident activity profile</p>

		<p>sheet.</p> <p>D16.3k, ARHSS 16.3g: Short-term care plans are being utilised and reviewed on an on-going basis. The care plans are monitored for integration of notes through the regular care plan audit last completed in September 2014 (100% compliance). Service delivery plans demonstrate service integration.</p> <p>E4.3 Two resident files reviewed from the dementia unit identified current abilities, level of independence, identified needs and specific behavioural management strategies.</p> <p>ARHSS 16.3g: Two resident files reviewed (psychogeriatric) identified current abilities, level of independence, identified needs and specific behavioural management strategies. Both residents had comprehensive behaviour management plans.</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>The care being provided is consistent with the needs of residents. The service actively links with community groups. The staff and facilities are appropriate for providing these services and are meeting the needs of residents.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use. Wound assessments are comprehensive and include type, location and body map, graph, Braden score, classification, factors delaying healing and any additional information. There is a wound dressing schedule and photographs for chronic or acute wounds (excludes skin tears). There are five wounds and one resident with two wounds being managed by the district nursing wound specialist (who managed the resident wounds when she was at home) across all units. Wound assessments and treatment schedules are current. Specialist wound management advice is available as needed and this could be described by the RN's interviewed.</p> <p>Continence products are available and resident files include an admission urinary and bowel continence assessment that is reviewed at least six monthly or earlier if there are any changes in resident continence. Continence products are allocated for day use, night use, and other</p>

		<p>management. Resident daily bowel records and hygiene cares checklists are maintained.</p> <p>Specialist continence advice is available as needed and this could be described by the RN's interviewed. Staff attended continence management in-services in April, June and September 2014.</p> <p>Monitoring forms in use included behaviour monitoring, blood sugar levels, neuro observations and vital signs. RN faxes to GPs regarding changes in resident health status, suspected infections, new admission, and medication requests sighted in the resident files sampled.</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>Tasman has three activities staff (one qualified diversional therapist (DT) and two completing ACE) that work a variety of hours to implement a planned seven days activities programme across all units. The activities team is supported and supervised by the national wellness support coordinator who overviews the monthly activities plan. Activities staff meet with the cook and the operations manager weekly for planning. The DT's develop a programme for each unit and there is close liaison with each other to ensure residents can attend entertainment or activities happening in other units. Resident preferences, including spiritual and cultural preferences and capabilities are considered in the delivery of the service activities programme. A residents meeting is held monthly at which the plan is discussed and the residents (and family members) have the opportunity to make suggestions. An annual plan of special monthly theme events is formulated. Musical entertainers are booked weekly and a monthly church service is held on-site. Twice a year there is a family gathering which includes a Christmas event and a mid-year event. Families can access information on events and newsletters on the organisations Facebook page.</p> <p>During the audit a variety of small group and individual activities are observed happening throughout the units from the morning until late afternoon. The hospital programme commences at 10am to 4.30pm and the dementia activities commence from 1.30-5.30pm in each unit.</p> <p>D16.5d Resident files reviewed identified that the 24 hour individual activity plan is reviewed when at care plan review.</p>

		<p>ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered is included in the lifestyle care plan. Residents are quick to feedback likes and dislikes to the activity officer. The activity care plan is developed with the relative (and resident as able) and this is reviewed at least six monthly.</p> <p>ARHSS 16.5g.iv: Caregivers were observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>D16.4a: Nursing care plans are reviewed regularly and care plans are evaluated at least six monthly and more frequently when clinically indicated. A multidisciplinary six monthly review is completed with input from the nursing and care staff, GP, physiotherapist, resident or family/whanau as appropriate. Short-term care plans are reviewed as required. There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes.</p> <p>There is evidence of on-going review and changes to the care plans in eight resident files sampled.</p> <p>D16.3c: ARHSS D16.3c: All initial care plans were evaluated by the RN within three weeks of admission</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>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>	<p>FA</p>	<p>The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. Policies are available to guide staff in this process. The service has a physiotherapist that visits weekly and a dietitian that visits monthly. There is good communication with the mental health for the older person's team and the psychogeriatric services. Residents' and/or their family/whanau are involved as appropriate when referral to another service occurs. Referrals were sighted in the resident files sampled.</p> <p>D16.4c: The service provided an example of where a resident's condition</p>

		<p>had changed and the resident was reassessed from dementia care to hospital level of care.</p> <p>D 20.1: Discussions with registered nurses identified that the service has access to a physio, a dietitian and nurse specialists from the DHB.</p>
<p><b>Standard 1.4.1: Management Of Waste And Hazardous Substances</b></p> <p>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>The service has in place management of waste and hazardous materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. These include, but are not limited to: a) sharps procedure and b) cleaning/chemicals procedures and c) exposure to blood or other body fluid contamination policy. There is an incident reporting system that includes investigation of these types of incidents. Chemicals are labelled correctly and stored safely throughout the facility. There is appropriate protective equipment and clothing for staff. Staff attended chemical safety training in July 2014 and chemical safety competencies have been completed. Ecolab supply the chemicals; provide the safety data sheets and conduct quality control checks on the effectiveness of chemicals. Waste management contractors deliver and collect the drums weekly. Infectious material is double bagged and disposed of into the general rubbish drum. Recycling occurs. An external contractor delivers and collects the approved containers for the disposal of sharps. Staff interviewed were able to describe waste management and chemical safety procedures.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current warrant of fitness that expires on 5 July 2015. The building, plant and equipment appear to meet the required regulatory standards. The service is divided into smaller home-like care units. Each unit has its own kitchenette, dishwasher, microwave, fridge, and oven, open plan dining and lounge areas. The décor is calming with bright artwork and adornments. Flowers on the tables added to the home-like setting. Furniture and fittings are selected with consideration to residents' abilities and functioning.</p> <p>The maintenance person checks the maintenance books in each nurse station for day to day requests. Hot water temperature is checked weekly at the nearest and furthest point from the heating source. There is a pool</p>

		<p>of contractors available for larger maintenance problems. Planned maintenance schedules are in place for internal and external building maintenance. All resident related equipment has been checked. Electrical testing of equipment is current. Contractors complete a work sheet and report that is forwarded to the operations manager. An environmental safety audit is completed six monthly. The service has a smoking policy and smoking is only permitted in designated outside areas.</p> <p>Residents were able to move freely inside and within the secure outside environments. The paths are flat and the exterior including the gardens are well maintained. The residents can enter/visit the other units from any of the external walk ways. There is shaded seating areas/gazebo and raised flower gardens. The units are spacious and wide corridors allow for the use of mobility equipment. Handrails are in place within the communal areas.</p> <p>E3.4d, ARHSS D15.3d: The lounge areas are designed so that space and seating arrangements provide for individual and group activities.</p> <p>ARC D15.3; ARHSS D15.3e: The following equipment is available, shower trolley, shower chairs, walking frames, gutter frames, over bed tables, commodes, pressure relieving mattresses, shower chairs, electric beds, ultra-low beds, roho pressure relieving cushions, hoist, resident transferring aids.</p> <p>E3.3e: ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required.</p> <p>E3.4.c; ARHSS D15.3b: There is a safe and secure outside area that is easy to access</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>Seven hospital and rest home rooms have ensuite; all rooms have a toilet and a hand basin. There is a large communal shower. Three dementia unit rooms have an ensuite; all rooms have a toilet and a hand basin. There are three large communal showers. In the psychogeriatric hospital unit there are two large communal shower rooms. The facilities are close enough and large enough to meet the needs of the residents. Fixtures, fittings and floor and wall surfaces are made of accepted materials for</p>

		meeting hygiene and infection control practices. Communal toilets and showers are well signed and identifiable. There are engaged/vacancy signs on the doors and privacy curtains. There are appropriately placed handrails in the bathrooms and toilets in the ensuite and communal areas.
<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>	FA	Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids and hoists. The bedrooms are personalised. The bedrooms in the dementia care unit have photos identifiable to the resident on their bedrooms doors. There are electric beds or ultra-low beds, all with memory foam mattresses
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>ARHSS D15.3d: Seating and space is arranged to allow both individual and group activities to occur.</p> <p>Each unit has a kitchenette and open plan dining and lounge areas. Furniture is arranged to allow residents to freely mobilise between the different areas of each home and to the outside. In all units, the lounges are accessible and accommodate the equipment required for the residents. Activities take place in the dining room or lounge area of each unit dependent on the type of activity.</p> <p>E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.</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>	FA	The service has in place policies and procedures for effective management of cleaning and linen practices. The laundry is located at the psychogeriatric end of the facility. The caregivers carry out the laundering of the linen and personal clothing. The laundry is able to operate throughout the night. Colour coded linen bags and laundry is sorted into these. Soiled laundry is sorted into different coloured bags or buckets to identify type of treatment required. There is a dirty/clean flow which is marked on the floor of the laundry and there is an external door to the outside. There is adequate washing and drying equipment to cope with the volume of laundry and personal clothing. The daily laundry

		<p>duties include the cleaning of lint from the dryers and maintaining a clean and tidy laundry area. The chemicals and oasis system are within a locked cupboard of the laundry. Cleaning equipment and chemicals are carried in a basket when carrying out the cleaning duties. There are two sluice rooms within the facility, one per three units. Protective equipment available in the laundry and sluice rooms is aprons, gloves and face shields. Families interviewed are very satisfied with the cleanliness of their relative's rooms and the care taken with personal clothing. A cleaning services audit carried out September 2014 scored 100%. A laundry services audit July 2014 also scored 100%.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The service provides staff training to implement its policies and procedures for civil defence, equipment and other emergencies. Fire safety and evacuation training is provided to staff during their orientation phase and at appropriate intervals. The following training was provided in 2014; fire safety and evacuation, civil defence/emergency response. There is an approved evacuation scheme (October 2003). There is someone on duty 24/7 with a current first aid certificate.</p> <p>D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Civil defence kit and water supply is in place and meets requirements.</p> <p>Resident rooms, toilets/showers and the lounge/dining areas have call bells. These also show up in other areas of the facility on panels. Emergency bells are heard throughout.</p> <p>The service policies and procedures require that contractors are appropriately identified and a Contactor's folder is well established. Security policy is in place and a daily security check is documented.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and resident rooms are appropriately heated and ventilated. Corridor heating is thermostat controlled. Air conditioning is available. Family members interviewed state the home is lovely and warm. Residents have access to natural light in their rooms and there is adequate external light in communal areas</p>

<p><b>Standard 3.1: Infection control management</b></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>	<p>FA</p>	<p>The infection control (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The infection programme is reviewed annually (November 2013), this was completed with ICNs across the organisations.</p> <p>The IC programme plan and IC programme description are available. There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the infection control committee at service and organisational level.</p> <p>The infection control programme that is linked into the objectives of the quality and risk management plan for 2014 to 2015. The IC programme includes six objectives that include performance indicators and evaluation. The quality committee includes a cross section of staff from all areas of the service. The IC meeting at Tasman meets monthly and at an organisational level six monthly.</p> <p>The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Hand hygiene notices are in use around the facility. There is a staff health policy and staff infection and work restriction guidelines. There have been no identified outbreaks since previous audit.</p>
<p><b>Standard 3.2: Implementing the infection control programme</b></p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The monthly infection control committee meeting includes IC as an agenda item. The IC committee is made up of a cross section of staff from across the service. The service also has access to IC consultant, Public Health, GP's and southern community laboratory infection control team.</p>
<p><b>Standard 3.3: Policies and procedures</b></p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff. Policy development involves the organisation IC nurses, the infection control committee and expertise from the regional clinical manager, quality and systems manager, and southern community laboratories. The manual</p>

<p>are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>included a list of amended policies.</p> <p>D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff. Infection control programme includes infection control objectives as part of the quality and risk management plan.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control nurse is responsible for co-ordinating/providing education and training to staff and is supported by the clinical nurse manager. There are internal and external sessions available for training. The IC nurse has completed on line infection control training.</p> <p>Resident/family education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of visitor education in the form of hand hygiene signs around the facility and at entrance ways. There is policy around provision of infection control education for family members. Advised that the three monthly family newsletter and family meetings are an opportunity for them to include relevant infection prevention information.</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 policy describes and outlines the purpose and methodology for the surveillance of infections. The IC nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and southern community laboratory infection control team who advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Infection control data is collated monthly and reported to the monthly infection control meeting. Infections are documented on the infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The IC programme is linked with the quality and risk management plan 2014-2015. The service</p>

		<p>benchmarks with other organisation owned services on a range of issues - infection control being one of them.</p> <p>Quarterly reports are also completed from benchmarking analysis. Monthly infection surveillance includes resident name, new/existing/acquired, type, symptom code, tests conducted, organism identified, treatment and whether resolved. Infection control surveillance outcomes are reported to all meetings and are included in the monthly staff bulletin. Analysis of trends is included in infection control meetings and an action plan established around good practice.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention and it reviews past assistance / interventions. The service reviews the entire care plan monthly if a resident has restraint and this was documented well in the three restraint files reviewed.</p> <p>These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. The RN / restraint coordinator is involved in the assessment process along with the family and GP. Care plans include a full description of the approved restraint intervention and monthly evaluation.</p> <p>Restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence such as a lap belt in a wheelchair. There is also a policy for Enablers. There are no residents with enablers. There are seven residents on the register assessed as requiring intermittent restraint. Four arm restraints and three T belts.</p> <p>E4.4a: The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on</p>	FA	<p>The restraint coordinator is a senior registered nurse and experienced in dementia care. The restraint approval process and the conditions of restraint use are recorded on the "restraint risk assessment consent and management form". Consent for restraint use is logged in the restraint</p>

<p>restraint use and this process is made known to service providers and others.</p>		<p>register. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP in partnership with the resident and their family/ whanau. The multi-disciplinary team is involved in the assessment process.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention. These are undertaken by suitably qualified and skilled staff in partnership with the family/whanau. Restraint risk assessment, consent and management form is completed and signed by the resident rep (family / EPOA), RN, and GP and this was documented in the three residents' files for residents who use restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The restraint policy requires that restraint is only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, be monitored closely and this is done daily using a monitoring form or for arm restraint in the progress notes. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. Three files were reviewed for residents with intermittent restraint. The review identified clear instructions for use of 'arm restraints' or t belts, approval process, risks and monitoring requirements.</p> <p>The risk assessment, consent, and management form addresses this criterion and the restraint intervention is fully described in the care plan with daily monitoring records completed by staff.</p> <p>The restraint register is in place and shows monthly evaluation. An updated register is completed each month and also shows discontinued restraints. This is also review at the Organisational restraint approval group meeting.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Three files were reviewed of residents requiring intermittent arm restraint' or t belts as a form of a restraint. The use of restraint episodes are evaluated in the care plan monthly and documented, if a change occurs it is documented at the time. All episodes are also reviewed by the</p>

		restraint coordinator monthly and by the restraint committee.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The restraint coordinator is a senior registered nurse. The restraint approval group at Tasman includes (but not limited to) a family representative, physiotherapist, GP, DT rep, management team, education coordinator. Restraint is discussed every month in the RN meeting. An organisational report is completed around restraint use/training/incidents.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>There is an RN based in the psychogeriatric unit 24/7 which is attached to the rest home/hospital. Additionally there is another registered nurse based in the hospital/rest home from 8.30 am until 4.30 pm. Operations Manager Mon – Fri, fulltime and Clinical Manager (RN) – 24 hours a week (in addition to other RN hours). At Tasman there is currently a house general practitioner (GP), physiotherapist (visits every two weeks currently) and a dietitian (visits monthly). There are also two organisational wellness support coordinators who oversee the activities programme.</p>	<p>There is one RN rostered over 24 hours a day and located in the PG wing. The contract with the local DHB states that the psychogeriatric unit and hospital unit can share a RN between 10pm -7am only if the service is under 50 beds. There is not always a RN rostered in the hospital as well as the PG unit between 4.30pm and 10pm.</p>	<p>Ensure RN covers meets the requirements of the ARC and ARHSS contracts</p> <p>90 days</p>

## 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, 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
<p>Criterion 1.1.12.1</p> <p>Consumers have access to visitors of their choice.</p>	CI	<p>A family focus meeting is held annually and is chaired by a director. Advised by the operations manager that staff do not attend this meeting as it provides opportunities for residents/families to talk openly and freely. Outcomes of this meeting are fed back to the operations manager and any issues that arise are dealt with through the quality improvement programme. The clinical manager and the operations manager have an open-door policy.</p>	<p>The service, as part of its commitment to holistic care has implemented a series of education sessions for families and friends, this ensures that families are well informed and are part of, and informed about, their family member's care and condition. There is an orientation for families course, this is voluntary for new families of residents to assist them with the transition into care. The orientation programme informs the family about care provided at Tasman. Three sessions introduce families to Tasman and also to aged care. The sessions cover getting to know us, what records we keep, what they can expect from us (vision and values) and some visiting tips. Families are also shown a video of one of the services GPs talking, and there is input from relevant outside speakers including a local lawyer.</p> <p>This course is followed by the 'Sharing the Journey'</p>

			<p>course; a short course for families of people with dementia based on the service's 'Best Friends Approach to Dementia Care'. The premise of the 'best friends' approach is that the service provides care and support that one could expect of a best friend. The course aims to enable family members to understand the dementia journey, and effective ways of both communicating with and managing their family member in care. It includes dementia and delirium, aspects of BPSD, effective communication techniques, tips for visiting and personal care issues. It is also an opportunity for families to meet each other and share experiences in a supportive environment.</p> <p>Families interviewed from the dementia unit (three) and psychogeriatric unit (four) were complimentary about the information received and the courses.</p>
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	<p>CI</p>	<p>A2.2 Services are provided at Tasman that adhere to the health and disability services standards. There is an implemented quality improvement programme that includes performance monitoring. There are well developed manuals for all areas of the service and include management, human resource, clinical, health and safety, kitchen, laundry and activities. Policies and procedures and associated implementation systems are in place to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>There is an internal audit schedule. It includes (but is not limited to): clinical compliancy, complaints management, environmental safety, health and safety, infection control, kitchen/food, household services, medications, quality and risk management, residents admission, resident care, restraint</p>	<p>Benchmarking with other Dementia Care NZ facilities occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents, staff accidents) and clinical record audits. At service level incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including on-going review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly Governance meetings. There are a number of quality improvement (QI) projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities. QI's are raised as a result of feedback, complaints, surveys, and discussions at handover. Once completed the QI's are logged in the six monthly statistics for health and safety/infection control/quality. There is a quality and risk management plan for 2014</p>

		<p>minimisation, staff education, incidents and accidents, and asset and maintenance review.</p> <p>Ten family members and nine residents spoke very positively about the care provided and were well informed and supported.</p> <p>D1.3: All approved service standards are adhered to.</p> <p>D17.7c There are implemented competencies for all staff including caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions .</p>	<p>to 2015. The plan is reviewed monthly at quality meetings to measure progress towards meeting the programme objectives. The education programme includes a comprehensive orientation programme with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling, and restraint. All care staff are supported to complete first aid qualifications and the ACE programme including dementia unit standards. The annual education programme is comprehensive and includes programmes designed and implemented by the service: "best friends" is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular "Best Friends Approach to Dementia Care" (putting yourself in their shoes) training is carried out for all staff regularly and this is key to living their values and philosophy.</p> <p>Wellness support advisors have been appointed for both the North and South Island. Their role requires knowledge and skills in this specialist area, and they provide support to the diversional therapy (DT) teams, provide Non Violent Crisis Intervention training and oversee the BPSD support staff in each facility.</p> <p>Two days of training and development were held for DTs recently. These days were an opportunity for sharing experiences and activity ideas and focus on developing robust activity care plans. At Tasman, two DTs attended these days and both reported increased ideas and enthusiasm following the training.</p> <p>A staff member at Tasman has been identified who could be available to support other staff to examine changes in behaviour and help to find creative solutions (the BPSD champion). The person would also be trained in Non Violent Crisis Intervention and provide a source of knowledge and skill in de-escalation techniques. This person works closely with</p>
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			<p>the Wellness Support Advisor and is able to seek advice and discuss issues as required.</p> <p>There is a regional clinical manager to lead and provide guidance to the clinical managers. Management coaching is provided. All clinical managers meet annually to discuss clinical issues or policy changes. There is supervision for all registered nurses (RNs). Mentoring of staff by more senior members is facilitated. Non-Violent Crisis Intervention training is on-going at Tasman and Intercultural Awareness Training is well implemented. In-service education sessions include input from external specialists and clinical policies and procedures are updated to reflect good practice. Families are provided with two programmes called 'sharing the journey' and 'orientation for families'. These provide information and support for family members in understanding dementia. Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. Tasman is divided into four small homes. The small homes mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel. The smaller homes also have a higher staff ratio.</p> <p>DCNZ provides a free staff wellness and workplace support programme to all staff, including RNs and managers. It is a confidential service provided by Workplace Support who provides an independent qualified facilitator who visits Tasman weekly. This person is also available to staff outside normal scheduled weekly visits if required. They offer staff advice and strategies for dealing with any work, relationships, lifestyle, and health issues they are</p>
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			<p>currently experiencing which may be compounded in the working environment, thus allowing staff to focus solely on the residents in their care.</p> <p>DCNZ also subsidises staff for four GP appointments per year as part of its staff wellness programme, to encourage them to seek early medical assistance. Staff can receive free flu vaccinations annually.</p> <p>DCNZ has commenced a falls project which connects with and embeds National projects ( ACC, DHB, MoH) and will implement them organisationally. The project includes the appointment of a resource nurse (RN) at Tasman to follow through on falls prevention strategies, monitor risk, review assessment processes and care planning. A falls prevention tool box – which includes current research, education packages and practical ideas – is currently being developed. Vitamin D uptake will be monitored and the use of hip protectors is encouraged. Falls mapping, ongoing analysis and benchmarking will identify all risk including peak fall times of the day and environmental factors. The monitoring of the use of antipsychotic medication will be strengthened as they continue to build strong relationships with their contracted GP.</p> <p>A continence resource nurse has been appointed. The objective of this role is to promote the DCNZ continence program with staff from all facilities through best practice education, evaluation and follow up, to advise on continence issues and support the maintenance of continence and ensures that appropriate use continence products. A further goal is to promote dignity and person centred care. The resource nurse visits all sites every three months. The resource nurse is based at Tasman home and brings these skills and competency to the team at Tasman on a daily basis.</p> <p>A skin integrity resource nurse has been appointed to promote and facilitate pressure area care management</p>
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			and skin integrity via the appropriate use of equipment, peer support, education and guidance. DCNZ promote evidenced best practice in collaboration with national and regional experts in both primary and secondary related services. The skin integrity resource nurse will implement cost effective strategies for evidence based care of residents.
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>Dementia Care NZ Ltd is the parent company for Tasman Dementia Care in Nelson. Tasman is governed by DCNZ who provide specialist dementia care services to residents in nine facilities around New Zealand. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. The vision for the organisation is: 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'. The service aims to achieve the vision by promoting the uniqueness of each person, acknowledging the immense value of each person and by promoting openness, honesty and integrity.</p> <p>Philosophy of care incorporates: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and involved in their loved one's care. They are encouraged to share their knowledge of their loved one to build trust and to promote honesty and openness; c) small homely units provides residents with a stable and familiar environment; d) staff are acknowledged as people with skills and abilities who have the potential to be a positive impact on residents, families and their work teams; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote</p>	<p>Tasman is governed by DCNZ who provide specialist dementia care services to residents in nine facilities around New Zealand. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. The vision for the organisation is: 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'. The service aims to achieve the vision by promoting the uniqueness of each person, acknowledging the immense value of each person and by promoting openness, honesty and integrity. Philosophy of care incorporates: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and involved in their loved one's care. They are encouraged to share their knowledge of their loved one to build trust and to promote honesty and openness; c) small homely units provides residents with a stable and familiar environment; d) staff are acknowledged as people with skills and abilities who have the potential to be a positive impact on residents, families and their work teams; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. The philosophy care is to promote participation in life activities, promote physical and emotional</p>

		<p>a purposeful life and involvement in the running of their home. The philosophy care is to promote participation in life activities, promote physical and emotional wellness.</p> <p>Dementia Care NZ Ltd has well established business, strategic, quality and risk organisational plans being implemented for Tasman. The operations manager of Tasman is responsible to the general manager and reports on a monthly basis on a variety of issues relating to the strategic and quality plan. She also provides a daily report to the general manager, the quality manager and the regional clinical manager.</p> <p>There is a current charter, organisational structure, and business plan as well as a current quality and risk organisational plan for 2014/2015. The quality programme is managed by the operations manager and a quality and systems manager for the organisation. The service has undertaken a number of organisational projects including end of life care, falls prevention, admission, continence management and skin integrity management.</p> <p>E2.1 The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.</p>	<p>wellness. This is well demonstrated at Tasman. The service monitors performance in a number of ways and evidence of on-going improvements identified. The operations manager completes monthly reports that analysis internal audits completed follow ups required, and progress to meeting quality projects, corrective action status, document/review changes and general. Monthly incident trend analysis. Progress towards meeting the quality and risk management plan is monitored quarterly at organisational level and the entire plan reviewed and re-developed annually by the quality team. Meeting minutes for quality committee, health and safety committee and infection control committee are comprehensive and include review of the organisational and local objectives against performance measures. Quality meeting minutes include review of infection control, health and safety, staff, families, restraint, education, quality audit outcomes, activities and marketing. Key performance indicators are benchmarked internally with similar levels of care within the organisation. Friends and family satisfaction surveys are completed annually (2014). Actions are identified and followed through as required.</p> <p>In 2014 the organisation has introduced a clinical governance group with a vision of 'all people being involved in Dementia Care New Zealand (DCNZ) being offered care and support in accordance with DCNZ vision and values. This means the care is provided in a homely atmosphere in which each person's body, mind and soul is nurtured so that each person is able to experience moments full of wonder and fulfilment in their life journey. Uniqueness is valued and each person is immensely valuable. Openness and honesty with all people is important. The clinical governance group has aspirational targets, scope and purpose documented. Additionally an operations governance group has been introduced with a vision to see the</p>
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			<p>world through the eyes of the customer – be it the resident, the family or the staff. This means that they will search for new and innovative ways of doing things. An importance is placed on strong leadership and a collaborative culture. Openness, transparency and honesty with all people.</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>CI</p>	<p>The service has a quality programme that is implemented in practice. Quality improvement data is analysed to identify trends and themes. This includes incidents, infections, hazards, audits and complaints. The service continues to maintain the quality programme and improve on areas of service delivery. Staff are knowledgeable about quality processes. Meeting minutes reviewed include: registered nurse; quality committee; infection control; health and safety; and internal management. Minutes reviewed document the discussion of all quality activities.</p> <p>The service has an internal audit schedule that is implemented. Internal audits are completed and actions identified.</p>	<p>Quality data gathered includes comprehensive templates to identify trends, actions and identification of resolution. Internal audits include quality improvement (QI) plan . The QI plans include identified problem, action and on-going evaluation of action undertaken. Audit results are collated and document. Results are then fed back to staff at appropriate forums. Meeting minutes reflect a culture of quality improvements and on-going review of practice. Monthly benchmarking analysis is completed that includes outcomes. Resident and family are provided with quality feedback and initiatives through newsletters and meetings. The quality meeting includes a discussion of new quality improvements, unresolved/outstanding quality improvements. The service is proactive in identifying QIs on an on-going basis and monitoring these until signed out as completed. The May 2014 clinical indicator analysis and outcomes report identified that falls were higher than NZISAC score of 11.09 in the two dementia units. The root cause was identified as deficient staff knowledge regarding falls and falls minimisation and suggestions for improvement included:</p> <p>Educating staff regarding falls and falls minimisation</p> <p>Increased supervision of residents especially during 1500-1900</p> <p>Prompt referral of high-falls risk residents to physiotherapist, GP and other members of the MDT</p>

			<p>Use of appropriate manual handling equipment and mobility aids</p> <p>Construction of an individualised falls management plan for each resident identified as a high falls risk</p> <p>The initiatives were introduced and the falls rate monitored closely until it was being sustained below the benchmark by October 2014.</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>A process is implemented to measure achievement against goals in the strategic business plan and quality and risk management plan. Formal review takes place six monthly.</p> <p>Tasman holds monthly quality meetings, monthly registered nurse meetings, home managers' meetings and the operations manager reports monthly to the directors of Dementia Care NZ.</p> <p>Internal audits are completed and include the identification of any issues and corrective actions where required. Corrective actions are discussed at the monthly quality meetings and monthly staff meetings and the service ensures that all corrective actions are followed through and signed off. Incidents, accidents, hazards, complaints, infections, education, activities, marketing, quality systems and restraint are monitored through the monthly quality meetings.</p> <p>Monthly internal benchmarking and quarterly QPS benchmarking of the service in areas but not limited to resident accidents and infections, staff accident are used to measure the effectiveness of the objectives of the quality and risk management plan.</p> <p>Resident meetings occur monthly in the dementia unit and the hospital unit and an annual family focus group is held.</p>	<p>The service is proactive in monitoring outcomes from their quality management programme through meetings, and quality reports, also through their vision and values and the impact on family through the family focus group. Reports provided to the monthly quality meeting include clinical manager/RN monthly report, education co-ordinator monthly report, quality and systems manager monthly report, activities team monthly report, marketing monthly report, and home managers' report. On-going quality improvements are monitored through all meetings and annual goals are evaluated. The family focus group meeting is held annually (last February 2014) with a director and five participants. An action plan was completed as a result of areas family members would like to improve. Team gathering meeting with staff June 13 included input into reviewing previous business goals and developing goals for 2013 - 2014. Six week post admission surveys provide early feedback to the service friends and family satisfaction surveys are conducted annually.</p>

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>CI</p>	<p>Education plan for 2014-2015 is an objective of the quality and risk management plan. Human resource manual includes - training and supervision, staff training, ACE programme, maintaining training records, performance management and appraisals policy and procedures.</p> <p>Discussion with the education coordinator for the organisation, the operations manager, clinical manager, six registered nurses and six caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements.. The annual training programme well exceeds eight hours annually. Additionally, all caregivers are supported to complete the aged care education certificate core and dementia standards. Five caregivers interviewed advised that they have all completed the ACE dementia training (one is still completing). The registered nurses attend external training days through the organisation.</p> <p>The operations manager attends training provided by the organisation in leadership and management, and attends organisational wide managers' meetings and training. An education coordinator is employed to oversee the organisation's education programme for all homes and is available to facilitate sessions. The education coordinator develops the annual education plan in conjunction with the operations manager. There are essential/compulsory attendance sessions. Other topics are added to the plan as required following feedback from audits, complaints, incidents/accidents, infection, health and safety issues and quality improvement initiatives.</p>	<p>A number of education initiatives are implemented at Tasman. The annual education plan is comprehensive and covers both compulsory and additional topics. Topics are included in the plan in response to and following feedback from audits (i.e.: fire competency re-written to include more relevant questions), complaints, incidents/accidents, infection, meeting minutes, health and safety issues and quality improvement initiatives. The organisation has developed a programme called 'best friends' which comprises three x one hour sessions for all staff. The programme is part of the annual education plan and includes promoting the approach that care staff are the residents 'best friend'. The education package includes role playing, and discussions to promote empathy, understanding dementia, communication with dementia residents and providing activities that are meaningful and resident focused. The programme is tied to the vision and values of the organisation. This year the training has further extended with the introduction of 'come into my world' training which is across three sessions. Non-violent crisis intervention training is also provided for staff annually to enable them to safely manage residents with challenging behaviours. Intercultural Awareness programme was developed in partnership with the Office of Ethnic Affairs using their in-house Intercultural Course contextualised by the service to suit the aged care sector. The course raises staff awareness of own and other cultures and how different cultures communicate. Further training initiatives implemented at Tasman include; programmes called 'orientation for families' and 'sharing the journey' which are designed for dementia resident's families to provide education, understanding and coping with dementia progression, understanding behaviours, and responding to behaviours. Eight family members interviewed (six dementia unit and two hospital)</p>
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			<p>confirmed that they felt well supported and appreciated the service's provision of education for them around understanding dementia. The organisation supports new grads with competency packages. In 2014 a new training to follow the 'best friends' training was introduced. A training programme called 'Come Into My World' was developed to help staff caring for those with dementia. Building on the 'Best Friends Approach to Care' training, and based on some validation therapy techniques, the course teaches new skills and knowledge to staff on their own journey in caring for someone with dementia.</p> <p>Skills and approaches include using reminiscence to help the person retrieve previous coping mechanisms, using genuine eye contact, matching and mirroring emotions, looking for meaning within the context of conversation, rephrasing and reflecting, using music and songs and making full use of the senses.</p> <p>The course encourages staff to explore their own reactions and behaviour, as well as to consider some of the ethical issues surrounding deception and accepting the world of someone with dementia as 'real'.</p>
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End of the report.