

Tamahere Eventide Home Trust - Tamahere Eventide Home & Village

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Tamahere Eventide Home Trust

Premises audited: Tamahere Eventide Home & Village

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 11 October 2016 End date: 12 October 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 78



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

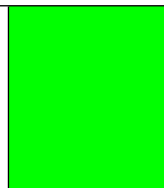
Tamahere Eventide Home and Retirement Village continues to provide rest home and secure dementia care. This re-certification audit was conducted against the Health and Disability Services Standards and the provider's contract with Waikato District Health Board (WDHB).

Changes to the organisation since the previous surveillance audit in November 2014 and a provisional audit in 2015 are; the establishment of a second secure dementia wing, restructure of the senior management team and an increase in the number of rest home level beds from 34 to 41 beds. In April 2016 the facility sought approval from the Ministry of Health (MoH) to deliver rest home care in seven of the internally linked apartments. Approval was granted conditional to the apartments being assessed as suitable at the next scheduled audit. Subsequently the people living in the seven apartments have been receiving care services. Parts of this audit focused on the effectiveness of the care services provided to them.

This audit process included the review of policies and procedures, the review of resident and staff files, observations, interviews with residents and their family, management and staff. The contracted general practitioner and a pharmacist were interviewed on site. This audit did not identify any areas requiring improvement. The provision of laundry services and the establishment of a Dedicated Education Unit (DEU) for nursing students were rated as continuous improvement, as changes in these areas resulted in improved services and increased satisfaction for residents.

Consumer rights

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



Standards applicable to this service fully attained.

Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of health and Disability Services Consumers' Rights (the Code). Families and residents interviewed expressed high satisfaction with the caring manner and respect that staff show towards each resident.

There are no known barriers to Maori or residents who identify with different cultures accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

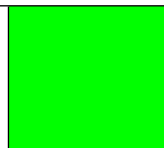
Written consents are obtained from the residents' family/whanau, enduring power of attorney (EPOA) or appointed guardians.

Residents are encouraged and supported to maintain community and family links.

The complaints management system meets the requirements of the Code and is known by staff, residents and their families. Families reported that staff immediately respond to and begin to address any concerns they raise. There have been two investigations by the district health board since the previous 2014 audit. These matters were fully resolved and are now closed.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

The trust board continue to meet monthly and are kept informed about all aspects of the organisation. The chief executive officer (CEO) and three other members of the senior management team are appropriately qualified for their positions and/or are experienced with working in the aged care sector. There are well established quality and risk management systems which meet these standards. The organisation continues to benchmark its quality data against similar services locally and nationally. Risk management systems are fully implemented.

All adverse events were being reliably reported and investigated. The organisation has made essential notification where required to the district health board and the Ministry of Health.

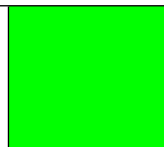
Staff are managed well according to policy and good employer practices. New staff have been recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff and has been strengthened by the new training co-ordinator. Ongoing staff education is planned and delivered in ways that ensure that staff receive relevant and timely training on subjects related to their roles and service provision to older people. Staff attendance at mandatory education sessions is monitored. Ongoing training is available to all staff through in-service teaching sessions, self-directed learning and presentations by external experts. Staff competency assessments and performance appraisals are occurring regularly.

There are sufficient numbers of clinical and auxiliary staff allocated on all shifts, seven days a week, to meet the needs of residents who are assessed as requiring rest home or secure level dementia care. The allocation of registered nurses (RNs) across the site 24 hours a day seven days a week exceeds contractual requirements.

Consumer information management systems meet the required standards. Archived records were being stored securely and all resident information is integrated and readily identifiable using relevant and up to date information.

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.

Pre-admission information clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

Residents on admission to the service are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops, with the resident and family, a care plan specific to the resident. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All residents have interRAI assessments completed and individualised electronic care plans related to this programme.

Residents are reviewed by their general practitioner (GP) or nurse practitioner (NP) on admission and assessed thereafter either monthly or three monthly depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

Activity coordinators provide planned activities meeting the needs of residents as individuals and in group settings. Families reported that the activities are appropriate and they are encouraged to participate in the activities of the facility and those of their residents.

A safe medicine administration system was observed at the time of audit.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes are catered for. The service has a four week rotating menu which is approved by a registered dietitian. Resident's nutritional requirements are met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are effective and safe processes for managing waste and hazardous materials.

The building has a current warrant of fitness. Electrical equipment is being tested and tagged by a registered electrician. All medical equipment is serviced and calibrated annually. Hot water temperatures are monitored.

All the bedrooms are for use by a single occupant and the apartments comfortably accommodate a couple. Each bedroom viewed was spacious and personalised. Communal areas are easily accessed with appropriate seating and furniture suited to the needs of residents. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Regular monitoring and reporting on the outputs from cleaning and laundry services contributes to good standards in these areas.

Emergency systems and the equipment needed for emergencies, including the ability to provide sufficient food and water for the number of residents for at least three days, is being checked frequently. There is an approved evacuation scheme and systems for ensuring that all staff attend six monthly fire drills. The RNs and a large percentage of care givers and key auxiliary staff are maintaining current first aid certificates. There is always a staff member with current first aid certificate on site.

Resident bedrooms and communal areas are heated in ways that provide comfortable and constant internal temperatures.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There were no restraint interventions in place on the days of audit. Seven residents had bed levers in place as enablers. The need for these had been appropriately assessed and consent obtained. Staff knowledge about the organisation's restraint free philosophy and their competence in preventing and minimising restraint practices is tested at least annually.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff and when appropriate the residents.

There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified and actions are implemented to reduce infections. The infection surveillance results are reported and discussed at staff and resident meetings and benchmarked internally and externally.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	2	91	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). New residents and families are provided with a copy of the Code on admission and included in the information pack.</p> <p>On commencement of employment all staff receive induction orientation training regarding residents' rights and their implementation. Education regarding consumer rights is held as part of the education calendar. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights in a manner that was individual to the resident's needs.</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</p>	FA	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents' files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA). Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in their relative's care and decision making.</p>

<p>make informed choices and give informed consent.</p>		<p>Residents interviewed stated that they were able to make their own choices and felt supported in their decision making. Staff interviewed acknowledged the resident's right to receive, refuse and withdraw consent for care/services. Staff were able to demonstrate good knowledge around challenging behaviours as evidenced in progress notes, care planning and observed at the time of audit.</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>All residents receiving care within the facility have appropriate access to independent advice and support, including access to cultural and spiritual advocates whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident's progress notes and care planning, such as visiting the local shopping centre or community groups regularly visiting the facility</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 complaint management system complies with right 10 of the Code and the requirements of this standard. Review of the electronic complaints register and interview with the CEO revealed there have been less than 20 complaints received since 2014. None of these were received by the Office of the Health and Disability Commissioner and two were received and investigated by Waikato DHB. Tamahere Eventide conducted an internal review and supplied information as requested to the DHB. The DHB made suggestions for changes to policy and /or process which have been implemented and the matters were resolved within an acceptable timeframe.</p> <p>All concerns, complaints or compliments are entered into the software system as soon as they are received. Details about the matter and its progress is then accessible to the CEO and authorised senior staff. Significant matters are discussed at monthly senior management meetings and reported to the board. Staff, residents and their family members interviewed demonstrated knowledge and understanding of the complaint process. Families described staff as being open, responsive and keen to address any matters they raised with them.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is also evidenced in the admissions agreement.</p> <p>The family/whanau and residents that were interviewed reported that the Code was explained to them on admission. Family/whanau and residents expressed that they were happy with the care at the facility and provided by the staff.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The family/whanau interviewed reported that the staff are meeting the needs of their relatives.</p> <p>The family/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.</p> <p>The family/whanau interviewed expressed no concerns in relation to residents' abuse or neglect. The family members reported that staff know their relatives well and are very good at intervening prior to and with any potential challenging behaviours. This was also evidenced at the time of audit with observed interactions.</p>
<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>	FA	<p>The General manager, registered nurse and caregivers interviewed reported that there are no barriers to Maori accessing the service. At the time of the audit there were no Maori residents who affiliated with their culture. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture and a Maori health plan was available.</p>
Standard 1.1.6:	FA	The spiritual, religious and cultural policy documents that the admission process includes assessing specific

<p>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>cultural, religious and spiritual beliefs. Staff liaise with family/whanau to ensure cultural or religious visits continue as appropriate.</p> <p>Education on cultural sensitivity and spirituality has been completed. Families and relatives interviewed were happy with the care provided by those staff who also identify with a different culture and enjoy the activities that are organised within the facility and within the community.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice was observed and evidenced in interviews with the registered nurses, caregivers and through care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' GP and NP, links with the mental health services, hospice, the geriatrician and different DHB nurse specialists and consultants. Care guidelines are utilised as appropriate.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit all residents spoke English. Where hospital/consultant appointments were planned the facility requested formal interpreters if required.</p> <p>The family/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidence adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at handover.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Tamahere Eventide now has a total capacity of 84 beds. Forty one of these are allocated as long term rest home care beds including one respite bed. A total of 43 dementia beds are available across the two secure dementia wings (21 beds in one wing and 22 in the other). There is one bed in each wing allocated for people requiring respite. On the days of audit there were 78 residents on site. Of these, 39 residents (including one person on planned respite) are receiving rest home level care. Seven of these were in the apartments. There was 20 residents in one of the dementia wings and 19 in the other, which included one person on respite. One of these residents was under 65 years of age.</p> <p>Tamahere Eventide has clearly described scope, direction and goals documented in its three year Strategic and Business Plan. The Chief Executive Officer (CEO), General Manager (GM) Care services, and General Manager Support Services report progress against the goals related to their service areas to the board every month.</p> <p>There have been minor changes within the membership of the board who continue to meet monthly. Review of the reports to the board showed they are provided current information on occupancy rates, health and safety matters, audit outcomes, staffing information, financial reports, information about complaints and compliments received, resident care, quality and other service delivery matters.</p> <p>The CEO who has been in the role for 20 years, has extensive experience as a manager in the health sector and is qualified in business management and leadership. The GM Care Services is a registered nurse with extensive clinical and managerial experience in aged care. Review of personnel files and interviews confirmed that all senior management staff are qualified for their roles and maintain their skills and knowledge by attending regular professional development and industry conferences.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>Discussions with the CEO, senior management and other staff confirmed that temporary cover during the CEO's planned absences is delegated to the GM Care services or the Support Services Manager. A senior registered nurse covers for the GM Care services. Staff stated these arrangements were proven to be effective and ensured continuity for staff, residents and their families.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>The organisation continues to review and modify its approach to quality management. The system is integrated with service delivery. Policies and procedures are reviewed at least two yearly and changes can only be made by</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>a member of the senior management team. A pre audit documentation review revealed that policies were current. Quality and risk matters are reported and discussed at a range of staff meetings. Review of meeting minutes reveals that resident care including their adverse events, health status, infections and behavioural concerns are discussed at monthly RN meetings and monthly 'wing' meetings for all staff rostered in those wings. The four senior managers review incidents/accidents, complaints, staffing, financial and project matters at their meetings and the health and safety committee consider staff injuries and the impact of environmental issues on services. Internal audits (of care records, safe medicine administration) are being conducted by the RNs and the supervisor or senior people in the kitchen, household services and maintenance team, to monitor their areas of service delivery. Where service deficits are identified through the internal audit system, or via an incident, a complaint or feedback from staff or residents and relatives, a range of corrective actions are discussed with relevant people and the most suitable actions are implemented. The organisation presents staff with quality awards to recognise individual initiatives or when they perform to a level above what is expected in their role.</p> <p>Tamahere Eventide continues to participate in the 'QPS' benchmarking programme with other aged care facilities. The organisation has at least 10 years of involvement in data capture. Initially they reported against 15 indicators, but they are now reporting against all 26 indicators within their service scope. This information is analysed to identify trends.</p> <p>Risk management processes are integrated with the quality monitoring system. The business risk management plan includes service provision, human resources, natural disaster planning, health and safety, contractual compliance and financial risks. The health and safety committee report all matters that require communication and discussion at staff and management meetings. Environmental checks to assess for health and safety are conducted regularly and reactive facility maintenance occurs. The hazard register is being updated as new hazards are identified. Chemical safety data sheets which provide information about hazardous chemicals are displayed in various locations on site. All accident / incident reports are considered by a multidisciplinary team as a means of identifying and preventing avoidable risks. Health and safety and essential emergency processes are mandatory topics during orientation and as part of the annual staff education plan. The interRAI assessment process identifies each resident's clinical risks and service delivery plans describe how these will be mitigated.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where</p>	<p>FA</p>	<p>There are well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed these are reviewed and discussed at staff meetings and then trended and further evaluated quarterly by the CEO and other senior managers. Avoidable events are evaluated and actions are implemented to prevent recurrence. Observation on the days of audit confirmed that incidents are discussed at shift handover, and trending data is displayed in the staff room. Each residents care record contains a summary of incidents which facilitates a ready review of risks. The CEO is responsible for essential notification and reporting and understands the statutory and regulatory obligations. There is evidence that the MoH and DHB were notified about a change in the General</p>

appropriate their family/whānau of choice in an open manner.		Manager Care services and also about a Norovirus outbreak in 2016.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The organisation is using good employment practices to recruit, employ and manage staff. Nine personnel records reviewed contain evidence that reference and police checking occurs prior to confirmation of employment. All registered health professionals are maintaining their practising certificates.</p> <p>Eight care staff, four RNs and the training coordinator interviewed and the staff files reviewed, confirm that all new staff complete an orientation programme. The orientation programme has been reviewed to make it specific to the type of role new staff are employed for and to integrate them to their work team and routines. The programme covers a variety of topics that are essential to the safety and security of the new staff member, residents and the organisation. A performance appraisal and competency assessment is carried out within 90 days of employment.</p> <p>Staff training is well planned and co-ordinated by a part time employed training coordinator. There was evidence in the training attendance records and staff files sighted and in staff interviews that all staff are provided regular opportunities to attend training that is relevant and specific to the role they are employed for. Care staff who work in the two secure units have either completed or are progressing achievement with the required unit standards in dementia care. This was confirmed by sighting copies of certificates and training spreadsheets.</p> <p>In 2015 Tamahere Eventide, the Waikato Institute of Technology (WINTEC) and Waikato DHB professional development unit entered a collaborative partnership with the goal of enhancing clinical teaching and learning in an Aged Care environment specific to rest home and dementia care. This resulted in the opening of a Dedicated Education Unit (DEU) as a joint venture pilot. In March 2016 the facility was presented with a “Best Clinical Placement Award, Bachelor of Nursing’ from WINTEC. Although this initiative supports student nurses on placement, an evaluation of the project showed that resident care and safety has been enhanced as a result. The organisation also benefits by being able to select two new graduate nurses each year whom they know have direct experience and knowledge of the facility to engage in the Nurse Entry to Practice (NETP) programme at Tamahere Eventide. This approach to the recruitment of RNs is resulting in longer term retention of registered staff in a younger age bracket. A continuous improvement rating has been achieved in criterion 1.2.7.3.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	FA	<p>Review of the rosters and interviews with management and care staff showed that the number of staff allocated on each shift in the rest home and the secure units exceeds the required contractual staffing levels. Care staff working in the special care units have completed or are in progress to achieve the required NZQA qualifications.</p> <p>There is at least one RN overseeing the care being delivered to rest home residents and those in the secure units seven days a week on each shift. There are sufficient numbers of care staff allocated for the number of</p>

<p>and/or experienced service providers.</p>		<p>residents in each wing, including those in the apartments. An additional RN is on call after hours.</p> <p>Diversional therapy staff are rostered in the secure units seven days a week from 10am - 8pm. All staff interviewed said that staffing levels are increased when workloads increase for any reason. The service employs an appropriate number of dedicated auxiliary staff (for example, cooks, cleaners, management, administration and maintenance staff) for the size and scope of the service.</p> <p>The RNs and GM care services stated that call outs from people living in the village does not negatively impact on staff resources in the home. It is the responsibility of the RN rostered to the rest home to attend and this is seldom required.</p> <p>Three residents living in the apartments stated they receive timely and competent personal care, cleaning services and support to attend activities daily. All other residents and family members interviewed expressed satisfaction with the availability of staff and the services provided.</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's name and date of birth and national health index (NHI) are used as the unique identifier on all resident's information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP and/or NP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP/NP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's record reviewed. No personal or private resident information was observed to be on public display during the days of audit</p> <p>All residents' files remain traceable and held within the required time frames which also encompasses the (Retention of Health information) Regulations 1996 act.</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>The resident admission agreement is based on the Aged Care Association agreement. The resident's records reviewed have signed admission agreements by the resident/family or EPOA.</p> <p>Vacancies are updated daily through Eldernet. Staff contact the facility manager if enquiries are made by potential perspective residents and/or their family members outside of normal working hours.</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>The service uses the (Situation, Background, Assessment and Recommendation tool) when communicating with all external services/support. DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Transfer of a resident to another facility includes notification to appropriate and required external services. Communication between the two services and with the family occurs prior to transfer and any concerns are documented. Documentation of an acute and planned transfer was sighted during the audit and was well completed.</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 policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, a process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit no residents were self-administering.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley in the office which is locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted and meets requirements. Medications that requires refrigeration are stored in a separate fridge.</p> <p>The 28 medicine charts reviewed have been reviewed by the NP every three months and are recorded on the electronic medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (prn) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administers medicines. All the electronic medicine files reviewed have a photo of the resident to assist with the identification of the resident and a pharmacy medication/tablet identifying sheet.</p> <p>There are documented competencies sighted for designated care staff responsible for medicine management. The registered nurse and caregiver administering medicines at the time of audit demonstrated competency related to medicine management. The pharmacist interviewed provides a 24 hour on call service and states that there are no concerns.</p>
<p>Standard 1.3.13:</p>	<p>FA</p>	<p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement,</p>

<p>Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. Kitchen staff interviewed have a very good understanding of food safety management and have completed or are booked to complete ongoing updated food safety training.</p> <p>There is a four week rotating menu. The menu has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>There are kitchenette's situated in the facility where residents/family can make their own hot and cold beverages.</p> <p>All meals are cooked and served directly from the kitchen at the time of the meal, with residents having the option of trays in their rooms. Three rest home residents whom reside in the facility apartments were seen to have their meals in the main dining room with options of having a tray in their room for breakfast. The cooking facilities in their apartments have been decommissioned.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The general manager interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (DSL) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and DSL service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded</p>	<p>FA</p>	<p>The service has implemented the electronic interRAI assessment and tools for all residents. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and include falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life, self-medication and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The residents' files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where a</p>

<p>in a timely manner.</p>		<p>need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure ulcer risk assessments.</p> <p>The family/whanau interviewed reported their resident receives 'above and beyond the care required' to meet their relative's needs.</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>The 14 residents' files reviewed have electronic care plans that address the resident's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the files. Also evidenced is the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The caregivers interviewed demonstrated knowledge about the individual resident's they care for.</p> <p>Residents' files reviewed included diversional therapy care plans identifying the resident's individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files reviewed showed input from registered and enrolled nurse, care and activity staff and medical and allied health services. The registered nurse and caregivers interviewed reported they receive adequate information to assist with the resident's continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book and progress notes.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</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>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the day of the audit, the registered nurse and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals. The registered nurse and caregivers interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>The activities programme uses a framework to empower the residents to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present</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>and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinator adapts activities to meet the needs and choices of the resident.</p> <p>The facility has five diversional therapists who combine cover Monday to Sunday 10am – 8pm and rotate four days on/four days off. The senior diversional therapist works Monday-Friday. The weekly activities plan/calendar sighted is developed based on the residents' needs and interests and can be easily adapted and changed depending on the residents' interest and reaction at the time. The activity coordinator advertises the upcoming activities on the calendar by providing residents on the notice boards daily through the facility and a monthly calendar of upcoming events is available. Care staff while supporting residents with personal cares remind and encourage residents to attend the activities. Regular activities include church services, regular visiting entertainment and includes trips to other events occurring in the community. Daily activities occur within the chapel and activities/dining room and the dementia unit. For residents that wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. Three residents who received rest home care and reside in the facilities apartments were evidenced to be included and partaking in activities at time of audit. The care staff interviewed state that they have access to activities to support residents after hours and on the weekends.</p> <p>The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements over a 24 hour period. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file six monthly.</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>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their GP/NP and family/whanau. Short term care plans are sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents' progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are discussed at handover; this was also evidenced at time of the audit.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are</p>

		changes in the resident's condition.
<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>	FA	<p>There is one GP and one NP who both visit the residents at the facility twice weekly. The facility is also supported by a 24 hour GP on call after hours service. The RN or the GP/NP arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The GP interviewed reported that referrals to requested services are well managed from the facility and no concerns are noted.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</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>There are clearly described policies and procedures for the safe and appropriate disposal of waste, and infectious or hazardous substances. These comply with local government and legislative requirements, the requirements of this standard and the provider's contract with the DHB. Visual inspection and interviews with care staff, and the household supervisor on the days of audit, revealed that chemicals were stored securely and that there is safe disposal of body waste and contaminated or potentially infectious products. Incontinence products are doubled bagged and bins are emptied to outside containers regularly. The sluice rooms in each of the wings were clean and well equipped. Personal protective equipment is available and was seen to be used on the days of audit. Staff interviewed demonstrated knowledge and understanding of safety issues around managing hazardous substances. Staff training records and interviews confirmed that all staff are provided with initial education and then ongoing information, and support by the organisation and external chemical suppliers.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for</p>	FA	<p>The buildings are being maintained in good repair and are fit for purpose. There is a current building warrant of fitness which expires in July 2017. Visual inspection of all internal and external areas revealed no environmental hazards. Interview with members of the health and safety team confirmed their vigilance in identifying, reporting and removing any potential risks to residents and staff. Interview with maintenance staff and the support services manager, review of records and observations on the days of audit showed that electrical testing and tagging is completed annually by a certified electrician, and calibrations of scales and medical equipment occurs as required for that the device. Inspection of the equipment revealed that fire safety equipment and the hoist are regularly checked for safety. All vehicles have a current warrant of fitness and registration. External furniture and</p>

<p>their purpose.</p>		<p>walkways were viewed as safe for use by the resident group and are being well maintained. Each building has access to outside sitting areas with protection from the elements.</p> <p>Each of the apartments occupied by residents requiring care services are internally linked to the main home and activity areas, have appropriately installed hand rails and have immediate access to safe external areas. Although each apartment has cooking facilities, the appliances have been decommissioned.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is sufficient numbers of communal toilets and showers in each wing of the rest home (for the number of residents in that wing) and in the two secure units. The facilities are conveniently located close to bedrooms and communal areas. Each door is lockable with engaged signs and there have been no reported issues with maintaining consumer privacy when attending to personal hygiene needs. There are separate staff ablutions. Hot water monitoring is occurring monthly and temperatures are well within safe limits of below 45 degrees. The temperature of all hot water outlets is moderated by tempering valves. This was confirmed by hand testing of taps in various locations during the onsite audit. Hand washing facilities and gel sterilizer units are strategically placed throughout the facility for staff and visitor use. Residents and families interviewed were very happy with the facilities provided.</p> <p>The apartments have disability accessible bathrooms with a shower, toilet and hand basin.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Walkthrough of the buildings revealed that bedrooms have a single occupant in them, except for a couple in the serviced apartments. The seven apartments were selected as suitable for delivery of care because of their generous size and configuration (for example the bed is in the main living area). The bedrooms are spacious and easily accommodate a bed, occasional furniture, chair and personal effects. There is enough room for residents to move around safely with or without a mobility aid. Residents and their families expressed satisfaction with their personal space. There are one or two electric beds on site, which are safety checked annually.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided</p>	<p>FA</p>	<p>Each rest home bedroom wing, including the apartment wing is readily accessible to activity areas, a choice of lounges, the chapel and reception area and the centrally located dining room. The secure units have their own lounge and dining areas. Residents and family members interviewed expressed satisfaction with the layout of the facility and communal areas. Residents were observed to be mobilising independently to utilise all areas within the facility on audit days</p>

<p>with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry and cleaning laundry services are safe and are monitored for effectiveness. Policies and procedures clearly describe the expected practices and are understood by staff. Cleaning staff are on site seven days a week for enough hours to complete the tasks allocated each day. There is a designated area for the storage of cleaning and laundry chemicals. Personnel records and staff interviews confirmed training is provided in safe handling of chemicals.</p> <p>Laundry services were fully contracted out to an external provider in 2014. This has resulted in a significant decrease in complaints and higher resident and family satisfaction. The addition of seven extra rooms for rest home care has been effectively accommodated within the laundry and cleaning systems. Criterion 1.4.6.2 is rated as continuous improvement.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Pre audit document review revealed the service has clearly documented emergency plans. On site interviews revealed that the emergency and security systems are well established and known by staff. There is a registered nurse or enrolled nurse on site 24 hours a day and an RN on call to provide support and increased response in emergencies. All staff are trained in fire safety and evacuation as part of orientation and at the six monthly fire evacuation drills. The fire evacuation scheme has been approved by the NZ Fire Service. Review of staff training records and rosters and interviews confirmed that staff receive extensive information on emergency procedures at orientation. Interview with the GM support service and maintenance staff and inspection of the emergency/civil defence stores confirmed there was sufficient stock of water, food, equipment and essential supplies in the event of a natural disaster. There is 160,000litres of stored water on site (4 x 40,000 litre tanks), and the facility has back up lighting and generators which initiate automatically in the event of power outage. The call bell system was observed to be functional during the onsite audit and families and families interviewed confirm that staff respond to call bells in a timely way. Residents in the apartments identified where their</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that</p>	<p>FA</p>	<p>All areas inspected in the facility were light, airy and at a comfortable temperature on the days of audit. Each room has at least one opening window and all bedrooms have individual heaters attached to the wall. Residents expressed satisfaction about the temperatures in their rooms and communal areas. The apartments have external sliding doors and heat pumps installed. Residents in these areas stated they were warm in winter and comfortable in summer.</p>

<p>is maintained at a safe and comfortable temperature.</p>		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>The infection control coordinator is the registered nurse. The infection control coordinator holds accountability and responsibility for following the programme in the infection control manual. The infection control coordinator monitors for infections by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meetings. If there is an infectious outbreak this is reported immediately to staff, management and where required to the DHB and public health departments.</p> <p>The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the electronic progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, at shift handover, in short term care plans and in resident's documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and</p>	<p>FA</p>	<p>The registered nurse has the role of infection prevention and control coordinator. Infection control issues are discussed at the two staff and resident meetings. The facility has the support of a clinical infection control specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources including the laboratory diagnostic services and GP/NP. The infection control coordinator has undertaken a yearly external course in infection control. The registered nurse and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed</p>

meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</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 are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>An infection control policy sets out the expectations the facilities uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including antibiotic use, MRSA screening, bandaging, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</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>	FA	<p>The registered nurse and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the registered nurse. Infection control in-service education sessions are held and resident education is provided, as and when appropriate.</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</p>	FA	<p>All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report. The service monitors respiratory tract infections, wounds, skin, ear nose and throat, urinary tract infections and gastroenteritis. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in health and safety committee meetings, staff meetings, and where appropriate, family meetings. An external contractor benchmarks surveillance data quarterly with other facilities.</p>

control programme.		<p>The Public Health office was notified on the 28th May 2016 regarding a gastroenteritis outbreak. Twenty four (24) residents, two staff, one student, one visitor were affected. A plan was developed and health warning signs/communication were put in place. Cleaning, laundry and personal hygiene were emphasised. A corrective action plan was sighted meeting all legislation and standard requirements which included education. Eighteen (18) residents in June 2016, 14 in July 2016 and three residents in August 2016 were reported to have respiratory tract infections. Documented discussions from internal and external sources suggested that residents affected by gastroenteritis with lowered immune systems and the seasonal weather changes at the time contributed to these higher than normal statistics. Two residents were also identified as requiring antibiotics due to frequent infections. Short and long term care plans were evidenced to document interventions to reduce and minimise the risk of infections and regular evaluations.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Tamahere Eventide is maintaining its philosophy and practice of no restraint which is appropriate for the consumer group and service setting. There are systems and processes for implementation of restraint if required. This has not occurred. Interview with the care manager and review of incident accident reports and staff meeting minutes revealed that when a resident's condition deteriorates and their safety is compromised, they are reassessed for transfer. There were seven voluntary enablers (for example bed levers) in use during the audit. Interview with the training coordinator and staff, and review of records revealed that training on restraint prevention occurs at orientation and at least annually.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	CI	<p>Review of a report that evaluated the impact of establishing a dedicated education unit for trainee nurses, and interviews with the CEO, RNs, the GM Care services and trainee nurses confirmed multiple benefits. The report cited a 57.89% decrease in aggression amongst dementia and rest home residents and a 20% reduction in resident falls across the facility, possibly due to the increased number of people providing direct care. The report gave examples of individual residents who were inclined to aggression, being more settled in the presence of students in white uniforms and another who had been totally dependent on staff for feeding, picking up a spoon to feed self-subsequent to 1:1 prompting by a student. The CEO reports an increase in the retention of registered nurses who have been employed subsequent to their student experiences and post graduate placements at the facility. Eight of the 12 registered nursing staff at Tamahere have completed training as a preceptor to support new entry to practice graduate nurses who are employed by the facility. This includes the training coordinator and GM care services.</p>	<p>Establishment of a dedicated education unit at the facility means there are more people on the floor to provide care and 1:1 time to residents which has resulted in measurable reductions in aggressive behaviour and preventable falls. As well as enjoying their time spent with students, rest home residents directly involved in the teaching expressed feelings of importance and empowerment knowing they are contributing to the skills of a future work force. The registered nursing staff who have completed training as preceptors say they have strengthened their portfolios and enhanced their practices by being more active in teaching students.</p>

<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>CI</p>	<p>Review of complaints, satisfaction surveys, and interviews with the CEO, staff, residents and relatives showed that complaints about laundry services decreased from receipt of one complaint a week to two complaints since the service was outsourced in 2014. Residents clothing is laundered to a high standard with reduced loss and damage and service linen is in good supply and in excellent condition. The only items laundered on site are cleaning cloths and some bedspreads.</p>	<p>Resident and relative satisfaction with laundry services has increased significantly since it has been contracted out. The quality and effectiveness of laundry services is monitored closely by staff and the contractor and where improvements were needed these have been implemented to a stage where non-compliance seldom occurs.</p>

End of the report.