

Tainui Home Trust Board - Tainui Resthome

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:	Tainui Home Trust Board
Premises audited:	Tainui Resthome
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 March 2018 End date: 16 March 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	51

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Tainui Resthome provides rest home and hospital (geriatric) level care for up to 60 residents. The service is operated by Tainui Home Trust Board and managed by a chief executive officer and a clinical manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents and staff files, observations and interviews with residents, family members, management, staff, contracted allied health providers and two general practitioners.

The audit has resulted in three areas of continuous improvement. These are related to responding to residents' spiritual needs, the introduction of cooking classes as part of the activities programme and changes to the menus. One area requiring improvement is identified, relating to the inclusion of all required support in residents' care plans.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

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

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents, are of an appropriate standard.

A complaints register is maintained and was up to date on the days of the audit. Complaints are resolved promptly and effectively with respectful communication to complainants.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the Trust. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in both integrated electronic and hard copy files.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents' files reviewed demonstrated that needs, goals and outcomes identified are reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

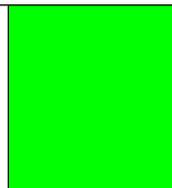
The planned activity programme is overseen by two diversional therapists and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

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

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and 11 restraints were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. An effective assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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 prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board, public health and the trust's external advisor. The programme is reviewed annually.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	0	1	0	0
Criteria	3	97	0	0	1	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>Tainui Resthome has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, advance directive requests, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were available at reception. The two chaplains act as residents' independent advocates and are onsite and on call always if needed. Interview with one of the advocates verifies knowledge and responsibility of the role, in addition to confirming management's prompt response to any concerns.</p> <p>Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</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>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to make a complaint. Complaints and compliments forms are available in places around the facility where residents and family members can freely access them along with a secure box to 'post' them.</p> <p>The complaints register reviewed showed that 10 complaints were raised in 2017, and four so far in 2018. All complaints had appropriate actions taken, had been managed through to an agreed resolution, and were documented and completed within required timeframes. When needed, action plans showed any follow up and improvements have been made.</p> <p>The quality assurance coordinator is responsible for ensuring complaints management occurs within required timeframes and that managers are following the relevant organisational processes. All staff interviewed confirmed a sound understanding of the complaint process, and what actions are required of them in their roles.</p> <p>There have been no complaints received from external sources since the previous onsite audit.</p> <p>In the resident and family satisfaction survey of 2017, one of the 19 respondents said there were often</p>

		<p>not people available to receive complaints. The remaining 18 respondents had either no strong opinion (three respondents) or were satisfied with the response to issues and complaints that were raised (15 respondents).</p> <p>Residents and family members interviewed during the audit stated they were comfortable raising any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</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>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and in discussion with families and the GP. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. A comprehensive spiritual assessment is undertaken on admission and is updated and reviewed on a regular basis. The services response to meeting the spiritual needs of residents, is recognised for its commitment to continuous improvement.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records reviewed.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as</p>	FA	<p>There are no residents in Tainui Resthome at the time of audit who identify as Māori, however interviews verified that staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of</p>

<p>Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers.</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>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</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>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Both general practitioners (GPs) interviewed, also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, clinical nurse specialist, physiotherapist, occupational therapist, speech language therapist, wound care specialist, community dieticians, services for older people and mental health services for older people.</p> <p>The service has a four bedded 'older persons health and rehabilitation service unit'. The Taranaki District Health Board (TDHB) provides the specialist input to the residents in this unit daily.</p> <p>The GPs confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for internal and external education. Two 30-minute</p>

		<p>interactive training sessions are held twice a month and evidence good attendance. Staff are supported to access training sessions at the TDHB, or training in-house by TDHB specialists and on-line training sessions. The organisation supports staff to attend conferences.</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>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the TDHB, however staff reported interpreter services were rarely required due to all present residents being able to speak English or having family members who can assist.</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>	FA	<p>The strategic business plan, which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. The document described annual and longer term objectives with the associated operational plans. A sample of bi-monthly reports to the Trust Board of directors showed adequate information to monitor performance is reported including financial performance, emerging risks and issues, adverse events, section 31 notifications and any other issues of which the Board needs to be notified.</p> <p>The service is managed by a chief executive officer who is a registered nurse with a practising certificate with a leadership scope of practice, and who has an MBA and has experience as a manager in the aged care sector. He has been at Tainui Village for five years. He is assisted in management of the aged care facility by a clinical manager who has been in the role for four years. She is an experienced registered nurse who has worked at the local district health board (DHB). Responsibilities and accountabilities for both roles are defined in job descriptions and both have an individual employment agreement. The CEO confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending conferences and forums run by the Retirement Villages Association (RVA) and the New Zealand Aged Care Association (NZACA) and reading clinical journals and articles. The clinical manager similarly maintains her clinical knowledge through attendance at internal and relevant external training.</p> <p>The service holds contracts (relevant to this audit) with the Taranaki DHB (TDHB) for aged related residential care, respite, long term chronic health conditions (LTCHC), and the EICAT rehabilitation contract. On the first day of the audit 51 residents were receiving services at Tainui Village, and three residents were in hospital at the TDHB. There were no residents receiving respite care* or funded by the</p>

		<p>LTCHC contracts. There were 38 residents receiving rest home level care; 34 under the ARRC contract and four under the EICAT rehabilitation contract. There were 13 residents receiving hospital level care all under the ARRC contract. All beds in the facility are approved for dual purpose care.</p> <p>*As Tainui Village has a co-located retirement village, residents of the village are able to access respite care through the Occupational Right Agreements (ORAs). On the days of this audit there were no retirement village residents utilising respite care although at other times there may be. All ORA units are outside the aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In a short-term absence of the CEO either the Clinical Manager or the Operations Manager will undertake the role of acting manager of the facility. If the Clinical Manager picks up these duties, her senior registered nurse will take over some of the clinical management responsibilities.</p> <p>At interview with staff members they reported that the management team are approachable and available when needed.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. The quality assurance coordinator was interviewed during the audit and described two changes to the quality management system which have occurred since the last audit. The facility has entered into an arrangement with an experienced contractor in the aged care sector who provides a range of services to aged care providers. Tainui is utilising the adverse event analysis, with benchmarking of data, and a complete suite of policies and procedures. This arrangement includes the policies and procedures being tailored to Tainui's systems and structure, ensuring they are reviewed regularly in conjunction with Tainui and cover all necessary aspects of the service and contractual requirements. All policies reviewed for the stage one audit were current, reflected best practice in the sector and were consistent with Tainui Village. There is a document control system which ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The adverse event system incorporates the management of incidents and accidents, compliments and complaints, internal audit, a regular resident and family satisfaction survey, and monitoring of clinical incidents including infections and falls. All event data is reviewed as it occurs and then is entered into an electronic database which allows for analysis and evaluation of identification of any trends. This database provides benchmarking of Tainui's adverse events with other similar aged care facilities and is part of the</p>

		<p>services provided by the external contractor.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at regular meetings including management and staff meetings. Staff members reported they receive information about audit activities through staff meetings and summarised quality improvement data is provided in graphed form in the staff room. Relevant corrective actions are developed and implemented to address any shortfalls. The electronic system was reviewed with the quality assurance coordinator and examples of adverse events, graphed data and benchmarked information provided on a monthly basis were seen.</p> <p>Resident and family satisfaction surveys are completed annually with the most recent survey completed in 2017. The overall satisfaction rating for Tainui Village was 94%.</p> <p>Since the last audit the facility identified some areas they wished to work on, and several projects are underway.</p> <p>During the interview with the CEO he described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk management plan is reviewed, and amended as needed, with two monthly reporting to the Board of Trustees. Examples of this were seen in sampled Board reports in 2017 and early 2018. The CEO and quality assurance coordinator are both familiar with the Health and Safety at Work Act (2015) and have implemented its requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an incident/accident form. A sample of adverse event forms reviewed showed these were fully completed, incidents were investigated, and action plans developed and followed-up in a timely manner. Adverse event data is collated, analysed and entered into the electronic database (see Standard 1.2.3). Staff members interviewed confirmed that they receive collated information at meetings and in graphed form.</p> <p>The quality assurance coordinator described essential notification reporting requirements, including for pressure injuries, and serious adverse events. They advised there have been seven section 31 notifications since the beginning of 2017, although three of these were for fractures which they have since understood are no longer required to be reported. A recent serious adverse event required reporting to other external agencies and review of documentation indicated that appropriate notifications had been sent.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff members new to their positions reported that their orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after three-months and then annually thereafter.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the TDHB. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process which provides safe service delivery, 24 hours a day, seven days a week (24/7). The clinical manager was interviewed in relation to how the care staff (RNs and caregivers) are rostered. At all times the facility is rostered as if they were fully occupied. There is flexibility within several part time shifts to adjust staffing levels to meet the changing needs of residents. The interRAI Acuity report, planned leave and the contracted full and part-time hours of some care staff members are also factors considered when changes may be needed.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24//7 RN coverage in the hospital.</p> <p>The two diversional therapists work regular hours each fortnight.</p> <p>The operations manager was interviewed in relation the house-keeping and kitchen staff. There are designated cleaning and laundry staff seven days a week. When needed laundry services may be outsourced. In the kitchen there is a cook on duty seven days a week, during the day and in the early evening, supported by kitchen hands.</p> <p>In the September 2017 employee survey, 31 of 34 respondents agreed with the statement 'The amount of work I do is reasonable.' Staff members interviewed during the audit also confirmed that there were sufficient numbers of staff.</p> <p>As noted in Standard 1.2.1, none of the retirement village ORA units are included in the certified bed</p>

		numbers.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the clinical nurse manager (CNM). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the TDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents self-administering medications at the time of audit, however appropriate processes are in place to ensure this can be managed in a safe manner.</p> <p>Medication errors are reported to the RN and CNM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process in relation to a recent medication error was verified.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietician in January 2018. Recommendations made at that time have been implemented. Documentation verified a food control plan was registered with the council in June 2017. Tainui Resthome is waiting for a verification audit of the plan.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p>

		<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and in resident meeting minutes. Any areas of dissatisfaction were promptly responded. This is an area recognised as one of continuous improvement. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance was available to residents as needed.</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>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Tainui Resthome are initially assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least six monthly unless the resident's condition changes. Interviews, documentation and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents, have current interRAI assessments completed by five trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</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>PA Moderate</p>	<p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was provided, documented in the progress notes and verbally passed on to relevant staff; however, this was not always well documented in the care plan. Care plans reviewed were not always reflective of the support needs of residents, the outcomes of the integrated assessment process and other relevant clinical information.</p> <p>Residents and families reported participation in the development and ongoing evaluation of care 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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care, except for care plan documentation referred to in criterion 1.3.5.2. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GPs interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by two trained diversional therapists, each working 33 hours per week.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included exercises, choir practice, care of a turtle and an aviary, spiritual meetings, visiting entertainers, favourite music sessions, readings, poetry, pampering sessions, quiz sessions and daily news updates. An initiative to improve residents' involvement in activities is acknowledged as an area of continuous improvement. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed</p>

		confirmed they find the programme meets their needs.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has several main medical providers, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this. Staff members interviewed stated that there are adequate supplies for protective clothing and equipment available for them. Supplies were observed in utility rooms, on the cleaners' trolleys, in the laundry and throughout the facility.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness expires 23 January 2019 and was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with the quality assurance coordinator and observation of the environment. The environment was hazard free, residents were safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</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 are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes bedrooms with ensuite toilets which share a closely located shower (five bedrooms), ten bedrooms which share five full ensuite bathrooms, and the remaining rooms all have their own full ensuite bathroom.</p> <p>There are appropriately secured and approved handrails in the toilet and shower areas, and other equipment and accessories are available to promote residents' independence when needed.</p> <p>In addition, there are designation visitor and staff toilets available in the facility. All toilets and bathrooms have appropriate security and privacy locks.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p> <p>All but two bedrooms provide single accommodation. The double bedrooms are of an appropriate size and configuration to accommodate two people.</p> <p>One of these two rooms is designated as the palliative care suite. It is privately located and has dual access, room for a family member to sleep with their relative. The second double room is only shared when approval has been sought. The palliative care suite was vacant on the days of the audit and the other double bedroom was occupied by a single resident.</p> <p>Resident and family feedback from the 2017 survey and during this audit was that the bedrooms are appropriate for resident's needs.</p>

<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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access additional areas for privacy, if required. This includes a chapel and library and additional areas with seating and tables are available for residents to read and take part in their own or small group activities. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry. Laundry staff members demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen.</p> <p>There is a designated cleaning team and one of the two staff working during the audit was interviewed. Chemicals were stored in a lockable cupboard when not in use and were in appropriately labelled containers on the cleaners' trolleys.</p> <p>The cleaning and laundry staff have completed required internal training and have either Level 2 or Level 3 NZQA qualifications, as confirmed in interview and review of personnel files.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. The most recent internal audit in January 2018 resulted in no formal corrective actions. The results were reported through the online database and through the management reporting system.</p> <p>The annual resident satisfaction survey in 2017 had a positive (94%) response for laundry and cleaning. Residents interviewed during the audit also reported that their laundry and cleaning was managed well and their clothes are returned in a timely manner.</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>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 2 October 1995. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 30 Jan 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas cooking facilities were sighted and meet the requirements for the residents in the facility. Water storage tanks are located around the complex, and there is a generator on site. Emergency</p>

		<p>lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</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 is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms, living and recreation rooms have natural light, opening external windows and all have views onto outside gardens. All residents' rooms and communal areas are heated and ventilated appropriately. Heating is provided with wall mounted radiators in residents' bedrooms and in communal areas.</p> <p>The facility was maintained at a comfortable temperature and all areas were well ventilated during the audit. Residents and families confirmed the facilities are maintained at a comfortable temperature throughout the year.</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>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed by an external advisor with input from the clinical nurse manager (CNM). The infection control programme and manual are reviewed annually.</p> <p>The senior RN with input from the CNM is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CNM and tabled at the quality/risk meeting. Infection control statistics are entered in the organisation's electronic database and benchmarked with other facilities. The organisation's quality manager is informed of any IPC concerns.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The infection control co-ordinator (ICC) has appropriate skills, knowledge and qualifications for the role, and is being assisted by the CNM and the organisation's external advisor. The ICC has undertaken on</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>line training in infection prevention and control and attended relevant study days with the TDHB, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC and CNM confirmed the availability of resources to support the programme and any outbreak of an infection.</p> <p>A recent loss of water supply to the region saw Tainui Resthome manage the risk, with the purchase of bottled water and wet wipes, and ensured no incidents of cross infection. There have been no incidents of norovirus at Tainui Rest Home in the past five years</p>
<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>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and 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>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, clinical nurse specialists (CNSs) and the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent loss of water supply to the region.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about hand washing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</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>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC and CNM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked with other aged care providers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, 11 residents were using restraints and one resident was using an enabler. The enabler was the least restrictive option and was used voluntarily. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with the restraint coordinator.</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 restraint use and this process is</p>	<p>FA</p>	<p>The restraint approval group, made up of the clinical manager, the diversional therapist and the restraint coordinator, are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the restraint coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>The restraint coordinator is the senior RN at the facility. She has been in the role for four months. She demonstrated a sound understanding of the intent of this Standard.</p> <p>Evidence of family/enduring power of attorney (EPOA) involvement in the decision making was on file in</p>

made known to service providers and others.		each case sampled. Use of a restraint or an enabler is recorded in each resident's care plan.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Five of the eleven residents who had approved restraints were sampled. This included the one enabler which is a chair placed at the end of a resident's bed at their request and provides reassurance. Assessments for the use of restraints were documented and included all requirements of the Standard.</p> <p>The RNs undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family / EPOA. The restraint coordinator described the documented process. Families' involvement was confirmed through records on the files samples.</p> <p>The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (eg, the use of sensor mats, low beds and de-escalation and recreation activities).</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every three months and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, three monthly restraint evaluations and at the restraint approval group meetings. Families involvement in the evaluation process is recorded on the evaluation form.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed</p>

		as required.
<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 approval group undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. This review was most recently completed by the current restraint coordinator in February 2018. Minutes of the meeting reviewed confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families.</p> <p>An annual internal audit that is carried out also informs these meetings. This last occurred in September 2017. Any changes to policies, guidelines, education and processes are implemented when needed.</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)
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Moderate	Four of nine care plans reviewed did not include documentation that fully reflected the required support the resident needed to achieve the desired outcome. There was no sighted documentation in the care plans to recognise the existence of the associated risks and required support needed to minimise the risks, in the following residents: a resident on anticoagulant therapy for deep vein thrombosis; a resident who had had a substantial injury following a fall and requiring a section 31 notification; a resident with compromised vision; and a resident who had had a fracture and now had a high risk of pressure injuries. Interviews, observation and additional documentation did, however, verify the required support was being provided.	Documentation in the care plans was not always reflective of the support required to meet the residents' desired outcome.	Care plans reflect fully the support required to meet residents' needs. 90 days

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.3.2 Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.	CI	<p>Evidence verified that there are two chaplains employed and present onsite at Tainui Resthome, 30 hours per week. They are also on call and available to residents and families at any time, providing residents, staff and families with counselling, prayer meetings and support.</p> <p>Feedback from residents and families (as recorded in meeting minutes), identified the chapel was too small and often overflowing, with some residents not being able to attend. If the chapel was required for private conversations it had to be closed off and church services had to be held in the large recreation room. Residents' feedback, identified the residents 'felt lost' in the recreation room, could not hear the service and had trouble following the service and reading the hymn books. A new chapel was created for residents, by transforming an underused craft room. The new space has enabled chaplains to hold daily prayer mornings, with more residents being able to attend. In addition, it has allowed the provision of small church services and funerals in a private space. The old chapel remains, as a second chapel when required. In addition, a screen and projector has been provided to assist the residents in following the service and hymns. Since the changes were implemented, attendance at prayer meetings five days per week has increased from six to 20 residents. Residents'</p>	The service has responded to the residents requests to expand and improve the services available to meet the residents spiritual needs. This has enabled more residents to attend services, an ability to focus on residents individualised spiritual needs, a more personalised approach in addition to an opportunity for smaller group meetings to occur if required.

		satisfaction surveys support the improvement in the services attention to meeting the residents' spiritual needs	
<p>Criterion 1.3.13.2</p> <p>Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	CI	<p>A review of resident meeting minutes and resident surveys over the previous year (July 2016 to July 2017) revealed ongoing dissatisfaction with the food service meeting the nutritional needs of the resident, specifically in relation to residents not being provided with a 'Choice' at meal times. Representatives from Tainui Resthome visited other facilities to view available meal options and had discussion with other providers at the providers' conference, in addition to discussion forums with the residents. It was decided with input from the kitchen and the dietician to create a completely new menu that rather than just offer a certain dish each meal time, was expanded to enable residents a choice of meals. The residents requests have been addressed by offering a range of choices at meal times, giving residents a choice of two hot dishes and/or salad at lunchtime. Previously the cook prepared the evening meal and it was reheated prior to being served. A chef is now employed at tea time and prepares such options as homemade rather than processed soups. In the longer term, the goal is to offer residents self-service. The menu is filled in by the resident the day before, and residents select which meal they would like.</p> <p>An evaluation of the changes has revealed approval of the new menu and no evidence of dissatisfaction with the food service in resident meeting minutes. Resident interviews and observation verified this finding.</p>	<p>Residents surveys identified residents at Tainui rest home, wanted more than a meal service that met their nutritional needs, they wanted a meal service that enabled them a choice each day over what they'd like to eat. The service has responded to residents' requests implementing a daily menu that offers a selection of food choices to be available at mealtimes and the availability of access to home cooked items. Evaluations verify improved satisfaction with the food service at Tainui rest home.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The diversional therapist had noted several new residents were reluctant to come out of their rooms and be involved with the existing rest home, hospital and village residents. They declined invitations to join in regular activities. It was decided to initiate a 'cooking class' for all residents to be able to attend, as cooking was something everyone could relate to. The response was positive, with initially 8-10 residents requesting to attend, however space was limited. A small kitchen was built in the recreation room, enabling all residents to attend. A coffee machine was also purchased. The cooking sessions are held fortnightly with 20-25 residents attending. The 'observed' session was social and interactive, with the diversional therapist preparing and cooking under the guidance and direction of the residents. Residents choose what to cook the next session. While the items are cooking, the diversional therapist initiates discussion and stories from the past. When the baking is complete</p>	<p>The implementation of cooking classes at Tainui Resthome, to encourage the involvement of more residents has seen an increase in resident participation and a decrease in the number of residents remaining in their rooms.</p>

		residents share the food with a coffee and a chat. Families are welcome to attend; however, it is recorded residents will make other arrangements if appointments or visits are at risk of compromising attendance at the cooking class. Residents are welcome to participate however choose to observe and advise.	
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End of the report.