

# Tainui Home Trust Board - Tainui Resthome

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Tainui Home Trust Board
<b>Premises audited:</b>	Tainui Resthome
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 15 October 2019      End date: 15 October 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	55

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Tainui Rest Home provides residential services at rest home and hospital level care for up to 60 residents. The facility is operated by Tainui Home Trust Board and is managed by a chief executive officer. Residents and a families reported the care provided is of a high standard.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, a general practitioner and allied health professionals.

An area requiring improvement from the previous audit relating to required support documented in the residents' care plans has been addressed.

Areas requiring improvement identified from this audit relate to the frequency of staff meetings, gaps in documented meeting minutes, circulation of resident meeting minutes and corrective actions as a result of the satisfaction survey and residents' meetings.

## Consumer rights

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

The quality assurance coordinator is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Tainui Home Trust Board is the governing body and is responsible for the service provided. Business and quality and risk management plans include the scope, direction, goals, values and a mission statement. The chief executive officer and other senior staff provide reports to the board on progress towards meeting the objectives.

The service is managed by an experienced chief executive officer who is suitably qualified. The chief executive officer is supported by the operations manager, the clinical nurse manager and the quality assurance coordinator.

There is an internal audit programme in place. Adverse events are documented on adverse events forms. Corrective action plans for deficits relating to internal audits and adverse events are developed, implemented, monitored and signed off. Quality, health and safety, registered and enrolled nurse, management, household and residents' meetings are held on a regular basis.

Actual and potential risks, including health and safety risks, are identified and mitigated.

Policies and procedures on human resources management is implemented. Human resources processes are followed. Staff have the required qualifications. An in-service education programme is provided, and staff performance is monitored.

A documented rationale for determining staffing levels and skill mix is in place. Registered nurses are rostered on duty at all times. Staff are rostered on call after hours.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents of Tainui Rest Home have their needs 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 comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and 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.

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, enrolled 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.
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A current building warrant of fitness is displayed. There have been no structural alterations since the previous audit.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraints and a resident using an enabler at the time of audit.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, data is 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	16	0	1	0	0	0
Criteria	0	38	0	2	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and complaints information and forms are available at the main entrance.</p> <p>There have been three complaints since the last audit, and these have been entered into the complaints register. Complaint documentation was reviewed, and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The quality assurance coordinator (QAC) is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required.</p> <p>The QAC reported there have been no complaint investigations by external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Residents and a families stated they are kept well informed about any changes to their own or their relative's status and 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</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the local DHB if required. Staff advised there are currently no residents who require an interpreter.</p> <p>Observation by the auditors evidenced effective communication and interaction between staff, residents and families. Residents and families confirmed this.</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>Tainui Rest Home is governed by a trust board that is responsible for setting the strategic direction and for the service at the facility. The Tainui strategic document 2019/20 includes a vision, four core enabling strategies – people first; excellent care; develop services; and not for profit/financially, and core indicators. The board meeting minutes evidenced identified objectives, with actions and progress on actions. The chief executive officer (CEO) reported they meet with the senior management team each Monday to discuss the activities within the service. The CEO and senior managers present reports to the board at their two monthly board meetings. Review of reports confirmed this.</p> <p>The facility is managed by an experienced CEO who has been in the position for six years. The CEO is an RN who has prior experience in leadership roles including the aged care sector. The CEO is supported by an experienced clinical nurse manager (CNM) who has been in the position for approximately six years. The CNM is supported by a senior RN. The CNM and senior RN are responsible for oversight of the clinical service. Review of their personal files evidenced they have undertaken on going education in relevant areas including conferences, updates and forums held at the DHB.</p> <p>Tainui Rest Home is certified to provide hospital level and rest home level care. Although the CNM reported all bedrooms have been approved as dual-purpose beds, rest home and hospital level residents are mainly cared for in designated areas.</p> <p>The service provider has contracts with the DHB for aged related residential care services (ARRC), respite, long term chronic health conditions (LTCHC) and enhanced intermediate care (EICAT). On the day of audit there were 13 hospital level residents and 39 rest home level residents under the ARRC contract, three rest home level residents under the EICAT contract and no residents under the respite and LTCHC contracts.</p> <p>Residents from Tainui village have occupational rights agreements (ORAs) and can access respite care in the facility if required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>PA Low</p>	<p>A quality and risk management system is in place. Quality data is managed well and is entered into an electronic programme provided by an external company. Graphs were observed in the clinical areas and include benchmarking. Various meetings apart from staff meetings are held regularly. Meeting minutes reviewed</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>evidenced there are gaps in the minutes documented. Staff meetings have not been held for some time and have been replaced with a weekly memo that is circulated around the facility. The memos evidenced reporting on quality data including trends. Staff stated they are expected to read the memos and sign off.</p> <p>The satisfaction survey for 2017 has been collated, however corrective actions have not been developed and implemented. The quality assurance coordinator (QAC) stated a satisfaction survey was not undertaken in 2018. Although the residents' meetings are documented, they are not made available to residents and corrective actions have not been completed.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures are reviewed and updated by the external company who provides them and were current. Obsolete policies are archived in the electronic system. Staff are notified via the weekly memo of reviewed and updated/new policies. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery.</p> <p>A risk management plan included a matrix and a hazard/risk register includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. All hazards are entered onto an adverse event form. The hazard/risk register includes actual and potential hazards and the actions put in place to minimise or eliminate the hazard. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood and implemented documented hazard identification processes.</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>Adverse, unplanned or untoward events are documented by staff on adverse event forms. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Policy and procedures comply with essential notification reporting. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The QAC reported there have been two Section 31 notifications to HealthCERT since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes</p>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>An orientation workbook includes competencies and all new staff are required to complete this. The workbook is</p>

<p>are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>completed within three months of employment. Staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers all essential components of the service provided.</p> <p>An in-service education programme is in place and covers all required subjects. 'Toolbox talks' at handover, specific topics relating to resident's health status and staff meetings and one to one training is provided. The local DHB also provides education sessions for RNs and staff attended other external education. Individual records of education are held on staff files and electronically. Separate registers are held for both RN/ENs and caregivers. Competencies were current including for medication management and restraint. Attendance records are maintained. Of the 11 RNs, five are interRAI trained, including the CNM and senior RN and have current competencies. All RNs and other staff have current first aid certificates.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. Care staff are currently completing level three.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their 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 rationale for determining staffing levels and skill mix to provide safe service delivery based on the Ministry of Health 'Indicators for Safe-Care and Dementia Care for Consumers' and staffing requirement in-line with the contract with the DHB. The rosters evidenced staffing levels exceed the minimum requirements. The CNM reported the rosters are reviewed continuously and dependency levels of residents and the physical environments are considered. The CNM and senior RN work full time. The rostering is divided for the rest home area and the hospital area. Each area has an RN or EN rostered on duty on the morning shift and an RN on the afternoon shifts. An RN is on the night shift and covers the two areas. The CNM or senior RN are on call for clinical matters and the operations manager for non-clinical matters.</p> <p>All the RNs have two to 12 years' experience, there are no new graduates employed. The two ENs have 20 to 30 years' experience. Caregivers are employed to cover the three shifts and additional hours are available if the acuity levels of residents increase. Laundry and cleaning is undertaken by dedicated staff. Two diversional therapists are employed and provide activities Monday to Friday.</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families reported they were happy with the staffing levels and there were enough staff on duty to provide them or their relative with a high standard of care. Observations during the audit confirmed adequate staff cover is provided.</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 was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an 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 who were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner, should this be required.</p> <p>Medication errors are reported to the RN and clinical manager (CM) 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 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</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 dietitian (June 1, 2019). Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the New Plymouth District Council. The expiry date of registration is 19 June 2020. A verification audit of the food control plan was undertaken by the council 12 September 2018. Three areas were identified as requiring corrective action and these were verified as compliant 20 November 2018. A new verification audit is due to occur at any time.</p>

<p>service delivery.</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, a 2017 resident satisfaction survey and resident meeting minutes. Residents are offered three meal choices at lunchtime, two hot dishes and a cold dish. At teatime there is a choice of soup, a hot meal or a light meal. Interview with the cook identified the cook gauges resident's satisfaction with meals at each mealtime, and any areas of dissatisfaction are attended to promptly. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The tables had tablecloths on and were presented in an appealing manner, that enhanced the dining experience. There were enough staff on duty in the dining rooms at mealtimes to ensure appropriate assistance was available to residents as needed.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. This finding addresses a previous corrective action, whereby documentation in the care plan was not always reflective of the required support the resident needed to meet their desired outcome. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the care provided to residents at Tainui was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of 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 levels of care provided and in accordance with the residents' needs.</p>

desired outcomes.		
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by two trained diversional therapists. A chaplain is on site seven days a week, to attend to residents' spiritual needs, in addition to a hairdresser and a nail technician. Twenty-two volunteers assist the diversional therapists to run the activities programme.</p> <p>A social assessment and history are 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 is diverse and 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, a resident cockatiel is cared for by residents daily, cooking sessions, knitting groups, a men's group run by a male chaplain, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the monthly residents' meetings and minutes indicated residents' input is sought (refer criterion 1.2.3.1). The latest, resident and family satisfaction surveys (2017), demonstrated satisfaction with the range of activities offered. Residents and resident's family members confirmed they find the programme meets the resident's needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care at Tainui 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 were sighted of short-term care plans being consistently reviewed for infections, pain and 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 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	FA	<p>A current building warrant of fitness was displayed that expires on the 29 January 2020. There have been no structural alterations since the previous audit.</p>

<p>accessible physical environment and facilities that are fit for their purpose.</p>		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance of infections at Tainui 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 ICN 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 graphs in the staffrooms and at staff handovers (refer criterion 1.2.3.1). 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 nationally against other aged care providers.</p> <p>A Norovirus outbreak in February 2019, lasted four days and was promptly contained. Documentation evidences the outbreak was managed appropriately in a highly efficient manner.</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 provided guidance on the safe use of both restraints and enablers. The restraint coordinator is the senior RN and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, there were four residents using a restraint and one resident using an enabler. There is a focus to reduce the use of restraint and the senior RN stated the aim is to be restraint free. Review of the register evidenced restraint use has decreased by five over the past 12 months. The senior RN reported apart from the use of equipment, effective education for staff around the use of restraints and assessing and monitoring why residents are falling and managing this better has helped. Families are actively educated around the risks associated with their relative using restraint. These measures in place have meant restraints are activity minimised. Staff interviewed demonstrated good knowledge concerning restraint minimisation and safe practice.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	PA Low	<p>Tainui has a quality and risk management system that guides the quality programme. Quality data is collected, collated and comprehensively analysed, including audits, incidents/accidents and clinical indicators and entered into the electronic programme. The programme produces graphs, reports and benchmarking with other like facilities. Graphs are comprehensive and provide good information.</p> <p>Staff confirmed that quality/management/infection prevention and control/restraint, RN/EN, health and safety, and resident meetings are held regularly. Meeting minutes reviewed evidenced there are gaps in the minutes being documented for the quality/management and RN/EN meetings. The resident meeting minutes are kept electronically and are not provided for residents to read. The QAC stated a satisfaction survey was not undertaken in 2018 and that the 2019 survey is about to go out to residents and families. Staff meetings have been replaced with weekly memos. Staff reported meetings have not been held for some time. The memos evidenced a variety of information including reporting back to staff of corrective actions and trends as a result of analysing quality data. The memos give instruction</p>	<p>(i)There are gaps in the documented meeting minutes for the quality/management and RN/EN meetings and as staff meeting are not held, minutes were not available.</p> <p>(ii)Resident meeting minutes are documented, however, they are stored electronically and not circulated</p>	<p>Provide evidence that:</p> <p>(i) minutes are documented for all meetings held;</p> <p>(ii) the residents meeting minutes are circulated following each meeting held;</p> <p>(iii) regular formal staff are re-introduced;</p>

		to summarise the memos at the afternoon, night and morning handover, write in the communication diary as needed, then file and staff are to initial when they have read it. However, not all staff are signing that they have read the memos. As staff meetings are not held, this method of communication means that staff are not able to formally discuss activities, information and instructions presented to them collectively and a record kept.	for residents to read.  (iii) Weekly memos have replaced the staff meetings and staff do not have the opportunity to discuss quality data, information and instructions as a collective.  (vi) A resident/family satisfaction survey was not undertaken in 2018.	and (vi) the resident/family satisfaction survey is undertaken on a regular basis.  90 days
Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Corrective actions are being developed and implemented following internal audits and adverse events and closed out. Although the satisfaction survey for 2017 has been collated, corrective actions have not been developed and implemented for deficits identified by residents and families. Resident meetings are held monthly and minutes documented; however, corrective actions to address areas requiring improvement have not be developed and implemented.	Corrective actions have not been developed and implemented for deficits identified in the 2017 resident/family satisfaction survey and the monthly resident meetings.	Corrective actions are developed and implemented to address all areas requiring improvement.  90 days

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

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

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

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

No data to display
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End of the report.