

Tamahere Eventide Home Trust - Tamahere Eventide Home & Village

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Tamahere Eventide Home Trust
Premises audited:	Tamahere Eventide Home & Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 19 October 2020 End date: 20 October 2020
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:	102



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

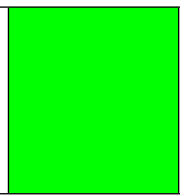
Tamahere Eventide Home and Village provides hospital, rest home and dementia level care for up to 107 residents. The service is operated by the Tamahere Eventide Home Trust Board who also own and operate a similar sized aged care facility-Assisi Atawhai Home and Hospital, which is located nearby. Both facilities are overseen by the same management team comprising of the chief executive officer (CEO) and general managers (GM). One GM oversees care services and the other oversees the village and support services, such as food and property matters. Each site has nominated senior leaders in clinical care, and in resident and staff support who report to the executive management team.

The most significant change at Tamahere Eventide Home and Village has been the commencement of hospital level care in January 2020 which increased the bed numbers from 83 to 107. Staff and stakeholders reported the change as seamless and this audit confirmed that the provision of hospital services has been successfully incorporated into all operational matters.

This recertification audit was conducted against the Health and Disability Services Standards and the organisation's contract with the Waikato District Health Board (WDHB). The audit process included review of policy and procedures, residents' and staff files, observations and interviews with residents and their family members, all levels of staff, the visiting podiatrist, nurse practitioner and the general practitioner (GP). Residents and relatives spoke positively about the care provided.

There were no areas requiring improvement identified at this audit. Two ratings of continuous improvement were awarded in the quality and risk standards for successfully increasing resident satisfaction and staff safety.

Consumer rights

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these are respected. Personal privacy, independence, individuality and dignity are supported. Staff interacted with residents in a respectful manner.

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.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents’ needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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

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

The trust board meet monthly and are kept informed about all areas of organisational performance. The chief executive officer (CEO) and senior management team are appropriately qualified for their positions and are experienced with working in the aged care sector. There are well established quality and risk management systems which meet the requirements in these standards.

The organisation continues to benchmark its quality data against similar services locally and nationally. Risk management systems are fully implemented. All adverse events were being reliably reported and investigated and essential notifications are made when required to WDHB and the Ministry of Health.

Staff are managed according to legislation and good employer practices. New staff are recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff by the onsite clinical nurse educator (CNE) and senior management. Ongoing staff education is planned and delivered in ways that ensure that staff receive relevant and timely training on subjects related to their roles and the care of older people. Staff attendance at mandatory education sessions is monitored. Ongoing training is available to all staff through in-service teaching sessions, self-directed learning and presentations by external experts. Staff competency assessments and performance appraisals are occurring regularly.

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to Tamahere Eventide Home and Village is appropriate and efficiently managed with relevant information provided to the potential resident/family.

Qualified personnel, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Waste and hazardous substances are managed safely. Staff use protective equipment and clothing. Internal and external environments meet the needs of residents and are kept clean and well maintained. Building systems are certified as safe. Electrical equipment is tested regularly. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Chemicals, soiled linen and equipment are safely stored. Regular monitoring and reporting on the outputs from cleaning and laundry services contributes to good standards in these areas. Laundry is undertaken onsite.

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.

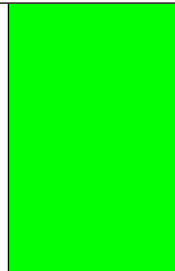
Restraint minimisation and safe practice

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler and four restraints were in use at the time of audit, these were all bed rails for safety. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. 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 trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	49	0	0	0	0	0
Criteria	2	99	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Tamahere Eventide Home and Village 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 understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent had been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented. Residents in the dementia units had activated EPOA's in their records. General consent forms for day to day care and for special procedures like the influenza vaccine were sighted in reviewed records. Staff were observed to gain consent for day to day care.</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. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. 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>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. The facility has implemented a private social media channel for the residents and family as an additional tool for contact with residents during the COVID-19 pandemic period.</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 of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns.</p> <p>The reviewed complaints register showed seven complaints recorded since January 2019. All had been investigated and closed. One matter which had been fully investigated and acknowledged to the family in an open and transparent manner, has subsequently been notified to the Office of the Health and Disability Commissioner (HDC). The organisation has since submitted evidence of the actions taken to address this and is awaiting a response from the HDC. Letters of acknowledgement, ongoing communications and records of investigations for all complaints had been completed within acceptable timeframes.</p> <p>The CEO is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The interviewed residents and family/whānau 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 the staff during the admission process. The Code is displayed on notice boards around the facility together with information on advocacy services, how to make a</p>

		complaint and feedback forms.
<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. Staff were observed to maintain privacy during provision of care throughout the audit. All residents have a private room. Shared facilities like bathrooms and toilets have signs that can be used when engaged to allow for residents' privacy.</p> <p>Residents were encouraged to maintain their independence for tasks they can do independently for personal cares, by attending to community activities and participation in clubs of their choosing. Care plans 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.</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 was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There were residents who identified as Maori on the days of the audit. Staff 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 whānau. There is a current Māori health plan developed with input from cultural advisers. A cultural assessment was completed for all residents who identify as Maori and a Maori health care plan developed as required. Guidance on tikanga best practice was available and was supported by staff who identify as Māori in the facility and a Māori cultural advisor who was engaged by the organisation. Māori residents and their whānau interviewed reported that staff acknowledge and respect their individual cultural needs.</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>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, for example, residents' spiritual needs. The resident satisfaction survey confirmed that individual needs were 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. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Tamahere Eventide Home and Village encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care specialist, psychogeriatrician and mental health services for older persons, and education of staff. The organisation has a dedicated clinical nurse education whose responsibility is to ensure annual staff education is completed for all staff and professional development for all qualified staff. The general practitioner (GP) and nurse practitioner (NP) 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 external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included employment of rehabilitation therapist who assists with functional assessments and provide regular exercise sessions for residents. During the COVID-19 pandemic restrictions, the service changed the roster to accommodate staff and residents' bubbles to maintain infection control measures.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/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 evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English.</p>
<p>Standard 1.2.1: Governance</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>and the associated plans for the two large-aged care facilities owned and operated by Tamahere Trust Board.</p> <p>A sample of board reports and interviews with senior management confirmed that detailed written and verbal information is provided to the board at least monthly. This information includes all aspects of the organisation's performances and includes emerging risks and issues.</p> <p>The commencement of hospital service delivery at the Tamahere site in January 2020 occurred seamlessly and this new service stream with an additional 24 beds has been successfully incorporated into the day to day operations.</p> <p>The service is overseen by a CEO who holds business and management qualifications and has been in the role for 24 years. Responsibilities and accountabilities are described in a job description and individual employment agreement. The CEO demonstrated knowledge of the sector, regulatory and reporting requirements and maintains currency through regular meetings with others in the aged care sector. The GM care services is a registered nurse with extensive experience in the delivery of age care services. This person attends regular forums in the age care sector and ongoing education in management and the clinical care of older people.</p> <p>As well as the Age Residential Care Contract (ARCC) for hospital, rest home, and dementia level care, to a maximum capacity of 107 beds, the organisation holds agreements with WDHB for residential respite services, long term support-chronic health conditions and community day programme services. Tamahere Eventide Home is also a dedicated education unit in partnership with the DHB and a tertiary provider for student nursing practicum placements.</p> <p>On the first day of audit there were 102 residents occupying beds. Forty-one residents were assessed as requiring secure care across the two dementia units, 37 were receiving rest home level care and all of the 24 hospital beds were full. Three of the 102 residents were there for short stay/respite, one in dementia care and two in rest home beds. These numbers were consistent with the Level of Care report held in the interRAI system. All residents were over the age of 65 years. There is a large retirement village on site. The CEO advised there were no retirement village residents with an occupation right agreement receiving care services in their homes.</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</p>	<p>FA</p>	<p>Discussions with the CEO, senior management and other staff confirmed that temporary cover during the CEO's planned absences is delegated to the General Manager (GM) Care services or the GM Support Services. One of the two clinical nurse leaders covers for the GM Care services and their roles are temporarily filled by a senior RN. Staff stated these arrangements were proven to be effective and ensured continuity for staff, residents and their families.</p>

ensures the provision of timely, appropriate, and safe services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	CI	<p>The organisation has a well-established quality and risk system which reflects the principles of continuous quality improvement. Responsibility for quality is shared across the senior management team with staff input at various stages. The system includes collation of key performance indicators/quality data which is submitted quarterly for comparison with like size age care facilities across New Zealand. The CEO and GM Care Services review and analyse all incidents, infections and complaints, and the results of resident and family satisfaction surveys for trends or areas requiring improvement. Criterion 1.2.3.7 is rated as continuous improvement for increased resident satisfaction.</p> <p>Outcomes of service performance monitoring via regular internal audits of clinical files, medicines, and residents' lifestyle are shared with all staff. Where the audits identify a need for improvement, the causes are researched, and remedial actions are agreed and implemented. This was confirmed by review of a sample of staff meeting minutes, in memos/time target messages and other forms of communication and by pictorial graphs displayed on the staff room walls.</p> <p>Quality data and information is reported and discussed at regular staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at meetings. The GM Care Services keeps staff informed about areas requiring improvement or policy/process changes by memos and verbally at meetings.</p> <p>The policies used are a generic system moderated by an external quality consultant and these cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>A current risk management plan is monitored by the CEO and the Board. All staff are conversant with the Health and Safety at Work Act (2015) and demonstrated knowledge of the requirements for identification, monitoring, review and reporting of risks and development of mitigation strategies. Criterion 1.2.3.8 is rated continuous improvement for the decrease in staff injuries and other successful initiatives that prevent harm.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	FA	<p>There are well established and managed processes for the reporting, recording, investigation and review of all incidents and accidents. Review of onsite documents and interviews with staff and management confirmed these are reviewed and discussed at staff meetings and then trended and further evaluated quarterly by the CEO and other senior managers. The number of resident falls per</p>

<p>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>group (rest home, dementia and hospital) are monitored for trends and reported to the board monthly. Concerted efforts with falls prevention strategies is revealing decreases in the number of falls in each area. For example, rest home falls with an average rate of 13% in 2019 are now tracking at 9% and in dementia care from an average 21.34% last year to 16% in the last quarter. All events considered preventable are reviewed in depth and strategies are implemented to prevent recurrence.</p> <p>Interviews and review of incident data during this audit confirmed that incidents are discussed at shift handover, and trending data is displayed in the staff room. Each resident's care record contained a summary of incidents which facilitates a ready review of risks.</p> <p>The CEO is responsible for essential notifications and reporting and understood the statutory and regulatory obligations under Section 31 of the Health and Disability Service (Safety) Act 2001. A notification related to a change of personnel in the senior leader clinical position was submitted in early 2020.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Staff 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. The sample of staff records reviewed 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. The methods for orientation continue to be reviewed to ensure all new staff complete essential education and are skills assessed before starting work. The monthly orientation days have been replaced with providing orientation to small groups of new employees as soon as possible to prevent delays in getting staff started in their roles. New staff reported that the orientation process prepared them well for their role. All the staff records reviewed contained records of completed orientation followed by an initial performance review after 90 days.</p> <p>Tamahere Eventide Home is successively maintaining its status as a 'dedicated education unit' in agreement with the Waikato DHB and WINTEC the local tertiary provider of nursing education. This provides nursing students with valuable learning experiences, increases and enhances the level of care provided to residents (as demonstrated by an evaluative study completed in 2016) and assists the service provider with the recruitment and retention of registered nurses.</p> <p>Education for all levels of staff is planned on an annual basis, which includes staff attending a day of mandatory training. All care staff are expected to commence age care sector training, as outlined in their pay equity settlement three months after commencing employment, if they do not already have qualifications. The clinical nurse educator is an authorised moderator of the education programme provided on site. Records reviewed demonstrated completion of the required training. Of the 73</p>

		<p>caregivers, 28 have completed level 4 of the National certificate in Health and Wellness, 14 are at level 3, 10 at level 2 and 21 are new employees or have equivalent experience or qualifications. All care staff working in the dementia units have commenced or completed advanced level 4 and dementia qualifications. Each of the staff files reviewed contained evidence of annual performance appraisals.</p> <p>Nine of the 21 RNs are maintaining annual competency requirements to undertake InterRAI assessments and two more are enrolled to undertake training. The service provider is aiming to have all RNs trained in interRAI.</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>	FA	<p>Review of the rosters with the person who manages the roster and interviews with management confirmed that the number of staff allocated on each shift in the hospital, rest home and both secure units exceeds the required contractual staffing levels. Four caregivers and one RN are rostered on for morning and afternoon shifts to work in the hospital wing (24 beds) and for rest home residents (maximum 41 residents). Three carers are allocated to each of the dementia units (maximum 20 residents) for the same shifts. Night-time allocation is one caregiver in each area/wing and two RNs-one in the hospital and one for rest home dementia, with another RN on call.</p> <p>Two Clinical Nurse Leaders (CNL) are onsite Monday to Friday to oversee the care being delivered to hospital and rest home residents and for residents in the two secure units.</p> <p>There are least at least two other RNs on site 24 hours a day, seven days a week (24/7). All RNs are maintaining comprehensive first aid certificates and a large number of care staff have the level 1 first aid certificate, which mean there is always a first aid certified staff member on duty.</p> <p>The care staff interviewed said there were sufficient numbers of staff for the needs of the residents allocated across all shifts. Additional staff are rostered on when workloads increase for any reason. The organisation has succeeded in eliminating the number of times it needs to use agency staff by growing their pool of casual RNs and care staff.</p> <p>The service employs an appropriate number of dedicated auxiliary staff (for example, cooks, cleaners, management, administration and maintenance staff) for the size and scope of the service. One diversional therapy (DT) staff are rostered in each of the secure units seven days a week from 9.30am-7.30pm. The hospital has a dedicated DT for six hours each weekday and four hours on the weekend.</p> <p>Residents and family members interviewed expressed satisfaction with the availability of staff and the services provided.</p>
Standard 1.2.9: Consumer	FA	Residents' information is electronically managed with copies of nursing, GP and allied health

<p>Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>assessments and care plans kept in residents' files. 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. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Staff had individual passwords to access the electronic residents' records.</p> <p>Current hard copy residents' records were kept securely in locked cupboard. No personal or private resident information was on public display during the audit. Archived records were held securely on site and were readily retrievable using a cataloguing system.</p> <p>Residents' paper records are held for the required period before being destroyed.</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>The admission process is managed by the clinical nurse leaders (CNLs) and their assistant. 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 are provided with written information about the service and the admission process. The organisation seeks updated information from NASC and GP for residents accessing respite care. Enquiry records are maintained and follow up completed by the CNLs. The EPOAs for residents in the dementia units have consented for admission.</p> <p>The interviewed residents 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. Service charges comply 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 DHB's '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/whānau. At the time of transition between services, appropriate information 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 appropriate documentation was completed. Family of the resident reported being kept well informed during the transfer of their relative. 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. There is</p>

		a clause in the access agreement related to when a resident's placement can be terminated.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>Tamahere Eventide Home and Village has a safe system for medicine management using an electronic system that was observed on the days of audit. The RNs' 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 were competent to perform the function they manage. Current medication administration competencies were sighted.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input was provided on request.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. 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>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are used, were current and complied with guidelines.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner when required.</p> <p>Medication errors were documented, analysed and corrective actions implemented.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a qualified chef and kitchen hands and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns in a six-weekly cycle and has been reviewed by a qualified dietitian in May 2020. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan</p>

		<p>and registration issued by Waikato District Council. Food temperatures, including for high risk items, were monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>Nutritional assessments were completed for each resident on admission to the facility, any allergies were identified, and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements were made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure dementia units always have access to food and fluids in a 24-hour period to meet their nutritional needs. Special equipment, to meet residents' nutritional needs, was available.</p> <p>Evidence of residents' satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>	FA	<p>The CNL reported that if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The resident and/family, where appropriate are informed of the reason for the decline.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity and nutritional screening, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. Behaviour management plans were implemented for residents in the dementia units.</p> <p>Care plans evidenced service integration with progress notes, diversional therapy notes, medical and</p>

		allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents in the dementia unit had their EPOA's involved in planning their care. Residents and families reported participation in the development and ongoing evaluation of care plans.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP and NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is implemented promptly. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources were available, suited to the levels of care provided and in accordance with the residents' needs.
<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 seven trained diversional therapists (DTs) holding the national Certificate in Diversional Therapy. Each wing has a DT allocated and most activities are provided in separate wings and combined activities are held when there are outside entertainers invited. Residents' needs, interests, abilities and social requirements were identified through a social history assessment by the DTs. Activities assessments were regularly reviewed to help formulate an activities programme that was meaningful to the residents. Six-monthly residents' needs evaluation was completed as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events were offered. Residents and families/whānau were involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme satisfactory.</p> <p>Activities for residents in the secure dementia units were specific to the needs and abilities of the people living with dementia. Activities were offered at times when residents were most physically active and/or restless. This includes van rides, exercises, games, quiz, pampering, relaxing music, sensory stimulation and garden walks.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes electronically. Interviewed care staff reported that any changes were reported to the RN.</p> <p>Formal care plan evaluations occur every six months following the six-monthly interRAI reassessment,</p>

comprehensive and timely manner.		or as residents' needs change. Where progress was different from expected, the service responded by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for urinary infections, respiratory infections and wounds. Unresolved problems were added to long term care plans. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<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	Residents are supported to access or seek referral to other health and/or disability service providers. The service has contracted GP services and residents are encouraged to enrol with the service's GP. If the need for other non-urgent services are indicated or requested, the GP or RNs sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to mental health team, hospice, physiotherapy, and cardiologists. The resident and the family/whānau 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>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.</p> <p>A new range of cleaning chemicals is in use. The products are provided in containers that minimise and prevent the risk of chemical spills and the wrong product being used. Another safety feature is that the containers cannot be opened without being connected to the trigger mechanism. An external company is contracted to supply and manage all chemicals and cleaning products and provide information about each to 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 ample provision and availability of protective clothing and equipment and staff were observed to be using this. Care staff and RNs were continuing to don masks before coming into close contact with residents and changing in and out of uniforms on site to prevent infection transmission.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are</p>	FA	<p>A building code of compliance is on public display which confirms the safety of building systems until 23.07 21. Emails from external contractors confirmed that this meets the building regulations since the usual issue of an annual building warrant of fitness has been impacted by Covid-19.</p> <p>Appropriate systems are in place to ensure the physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical</p>

<p>fit for their purpose.</p>		<p>equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.</p> <p>The service provider continues to invest in new approaches that maximize environmental safety, eliminating hazards, keeping residents safe and promoting their independence. For example, extra depth artificial grass was procured to minimise the impact of resident falls in an external area in one of the dementia units.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</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. Each of the 24 hospital rooms has a fully accessible bathroom and there is a large bathroom with a bed bath and spa bath (with ceiling hoist) in the new hospital wing. Nineteen rest home rooms have ensuite bathrooms plus there are another 11 bathrooms available for a total of 40 residents. The two dementia units have at three clearly identified toilets for resident use (in each unit) and at least three showers. There are five staff and visitors' ablutions located throughout the building. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Hot water temperature monitoring occurs monthly in all areas. Records of these showed that temperatures do not exceed 45 degrees Celsius.</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. All bedrooms provide single accommodation. Some of the older rest home rooms have adjoining doors if a couple desired neighbouring rooms. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>Each rest home bedroom wing is readily accessible to activity areas, a choice of lounges, the chapel and the centrally located dining room. The hospital wing and both secure units have their own lounge and dining areas. Residents and family members interviewed expressed satisfaction with the layout of the facility and communal areas. Residents were observed to be mobilising independently to utilise all</p>

<p>safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>areas within the facility on audit days.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry and cleaning services are safe and are monitored for effectiveness via internal audits and by the external chemical provider. Policies and procedures clearly described the expected practices and are understood by staff. Cleaning and laundry staff are on site seven days a week for enough hours to complete the tasks allocated each day. There are designated areas for secure storage of cleaning and laundry chemicals. A new and reportedly safer system for chemicals has been implemented (refer criterion 1.4.1) Personnel records and staff interviews confirmed training is provided in safe handling of chemicals; there have been no incidents of harm related to chemicals reported.</p> <p>New cleaning equipment has been purchased to maximise resident and staff safety. This comprises cordless and 'backpack' vacuum cleaners to prevent tripping and reduce back strain for staff. New 'wonder mops' and steam cleaners that reduce the amount of wet areas left on floors have replaced the older style mops. The number of staff back and shoulder injuries has reduced by 50% (refer to the CI rating in 1.2.3.8).</p> <p>Ironically the system for laundry which was outsourced in 2014 and deemed a success, was taken back in house in 2019 as a result of resident and relative feedback. Reverting back to an onsite system has immediately reduced complaints about loss and damage and residents are thrilled to have their personal laundry cleaned and returned to them on the same day. The extra demand on cleaning and laundry from the addition of 24 more beds has been successfully catered for by allocating additional staff or staffing hours. For example, there is an extra laundry staff member on site each day who folds and distributes clean laundry.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Tamahere Eventide Home has clearly described emergency plans which are updated whenever the service or the site is reconfigured. Onsite inspection and interviews revealed that the emergency and security systems are intact and known by all levels of staff. Fire safety and evacuation are included at orientation and six-monthly fire evacuation drills occur. Staff attendance at least one fire drill each year is monitored by the CNE and checked during annual performance appraisals.</p> <p>The fire evacuation scheme was updated to include the new hospital wing and approved by Fire and Emergency NZ in December 2019.</p> <p>Interview with the GM support service and maintenance staff and inspection of the emergency/civil defence stores confirmed there was sufficient stock of water, food, equipment and essential supplies in the event of a natural disaster. There is 310,000 litres of accessible water on site which well exceeds the</p>

		<p>recommendations set for the region by the Ministry of Civil Defence and Emergency Management. All buildings are fitted with emergency back-up lighting and two onsite generators which initiate automatically in the event of power outage.</p> <p>The call bell system was observed to be functional during the onsite audit and residents interviewed said that staff respond to call bells in a timely way.</p> <p>Emergency call activations from village residents are attended to by staff employed for the village during business hours. After this time, the calls have been coming through to staff in the rest home. Although these activations seldom occur (on average once a month) and there are sufficient staff on site to respond, the leadership team are investigating external services to triage village call bells.</p> <p>Entry and exit to TEH is secured by a perimeter fence and electronic gates. There are closed circuit television recording systems in the common areas and hallways (which residents and/or the people authorised to consent for them) have agreed to. The site is also patrolled during the night by a security company.</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 areas inspected were light, airy and at a comfortable temperature on the days of audit. Each room has at least one opening window and all bedrooms have the ability to adjust the amount of heat being radiated by the central heating system or by heat pumps. There have been no concerns raised about the internal winter or summer temperatures. Residents interviewed said they were comfortable in their rooms and in the communal areas.</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>Tamahere Eventide Home and Village has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external infection control specialists. The infection control programme and manual were reviewed annually.</p> <p>The CNE is the designated IPC coordinator, whose role and responsibilities are defined in their job description and infection control policy. Infection control matters, including surveillance results, are reported monthly to the chief executive officer (CEO) and GM care services and tabled at the quality and risk committee meeting. This committee includes the GM care services, representatives from food services and household management.</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</p>

		responsibilities.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role. She has completed training in infection prevention and control and has attended relevant study days, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The IPC coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. Adequate resources were sighted on site on the days of the audit. COVID-19 pandemic infection control measures and monitoring processes were implemented.</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>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in January 2020 and included appropriate referencing. The COVID-19 pandemic plan was in place.</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. Hand washing and sanitiser dispensers were 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>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education is provided by CNE. 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 was evidence that additional staff education has been provided in response. An example of this occurred when there was an outbreak of Norovirus in 2019. Appropriate notification was completed. Additional education was provided for the COVID-19 pandemic.</p> <p>Education with residents was on a one-to-one basis and has included reminders about handwashing,</p>

		use of hand sanitisers, advice about remaining in their room if they are unwell.
<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>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plan were discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data was collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous months and this was reported to the clinical nurse leaders, all staff and IPC committee. Data is benchmarked externally with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>Learnings from COVID-19 pandemic symptom monitoring measures have been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards. These provide guidance on the safe use of both restraints and enablers. Tamahere Eventide Home used to have a philosophy and practice of no restraint previous to delivering hospital level care. Each of the newly acquired hospital beds has in built bedrails which are used when required for resident safety according to the documented procedures. The hospital/rest home CNL is the designated restraint coordinator. This person provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding her role and responsibilities and the organisation's policies and procedures.</p> <p>On the days of audit, four residents were using bedrails as restraints and one rest home resident had a bedrail being used voluntarily at their request as an enabler. The same processes for assessment, consent and monitoring is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the clinical files and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p>	FA	<p>The restraint coordinator and GP are responsible for approving the use of restraints and overall restraint processes. Residents' files and interviews with the coordinator confirmed there are clear lines of accountability, that all restraints have been approved before use, and that the overall use of restraint is</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 made known to service providers and others.</p>		<p>being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>
<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>	<p>FA</p>	<p>Assessments for the use of restraint were documented to the level of detail required in this standard. An RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The restraint coordinator and another RN interviewed readily described all aspects of the assessment process. Families interviewed confirmed their knowledge and involvement in the process. The general practitioner is involved and makes the final decision on 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 each of the four clinical records for the residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members (for example, the use of sensor mats, and low beds).</p> <p>When restraints are in use, regular monitoring occurs to ensure the resident remains safe. The monitoring records contained all expected and necessary details. Access to advocacy is provided if requested and processes to ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each RN meeting. The register accurately recorded all residents currently using a restraint and sufficient information to provide an auditable record (for example, the type of restraint, date of commencement, and date for review or when it was stopped).</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>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, and at RN meetings. Families interviewed confirmed their involvement in the evaluation process and said they were happy with the restraint process.</p> <p>The evaluation covers all requirements of this standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and that documentation was completed as required.</p>
<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>	<p>FA</p>	<p>The use of restraint use is reported at RN, quality/risk and general staff meetings. Minutes of the meetings reviewed confirmed this includes 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 GP or nurse practitioner, staff and families. The service has been using restraints for less than six months and was preparing to conduct their first formal quality review of restraint practice at the time of audit. The mechanisms in place for reviewing compliance with procedures, reporting at staff and quality meetings and review of the individual restraints in use meet this requirement in the interim.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>Tamahere Eventide Home (TEH) evaluates the quality of its care against the same set of clinical indicators every quarter. The ratings from these indicators allow them to measure positive or negative trends and also compare themselves with other similar sized aged care services across New Zealand. The organisation compares very favourably and consistently sits in the top range. The most recent clinical file audits and the resident lifestyle index scored 95% and 92.5% respectively. Another example of service improvement is the total number of interRAI assessments completed on time. In 2019 this averaged 93%, this year the average score is 98%, despite the interruption during Covid-19.</p> <p>The outcome of the 2020 Resident Experience survey showed a 4% increase in satisfaction. All of the 13 areas surveyed scored higher than 85% with an overall increase from the previous 2019 result from 85.83 % to 89.20 %.</p>	<p>Resident overall satisfaction has increased another 4% this year as a result of efforts made to improve the services delivered to them. Residents rated their experiences higher than 85% in all areas surveyed and in the 90-percentile range for care, treatment, accommodation, wellbeing and satisfaction.</p>

		<p>Care approach, medical and therapy, general living accommodation, wellbeing and overall satisfaction all rated highly in the 90-percentile range. The most significant increase in scores was for cleaning and laundry, which was attributed to bringing laundry services back in house.</p> <p>There are very few complaints considering the size and complexity of the service (seven complaints in 22 months for 102 beds), no significant events have had to be notified under section 31 and the feedback from residents and families interviewed was very positive.</p>	
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	CI	<p>Risk identification and mitigation processes for residents, visitors, and staff at TEH are well embedded and are proving to be effective in achieving above the desired results. The effectiveness of the system and its component parts (risk management plan, policies, hazard register, environmental inspections, staff knowledge and adherence to safe practices) are moderated by an actively engaged health and safety team who have the authority to take immediate actions when needed.</p> <p>The 2020 employee survey showed an overall increase in staff satisfaction from 84.97% in 2019 to 88.31% in 2020, with their perception of Workplace Health and Safety increased from 89% to 91%.</p> <p>Accident and incident data revealed that staff injuries had reduced 50% since implementing new systems for cleaning and laundry. Refer to evidence in standard 1.4.6.</p> <p>The organisation is also focused on raising awareness of and preventing workplace bullying, through regular education, promoting teamwork, ensuring a fair and equitable working environment, and celebrating success in these areas.</p> <p>Ongoing improvements to safety in the residents' environment is cited in the evidence for Standard 1.4.2, and</p>	<p>Mitigation of actual and potential risks for residents, visitors and staff is effective in reducing injury as demonstrated in the results from performance monitoring. Systems are regularly evaluated, and changes are implemented immediately to prevent harm from injury.</p>

		<p>improved systems for the prevention of resident injury from falls is cited in the continuum of care standards.</p> <p>Furthermore, the organisation continues to provide a higher numbers of registered health professionals on each shift than they are contractually required to.</p>	
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End of the report.