

Tasman Rest Home and Dementia Care Limited - Tasman Rest Home & Dementia Care

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 BSI Group New Zealand Ltd, 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:	Tasman Rest Home and Dementia Care Limited
Premises audited:	Tasman Rest Home & Dementia Care
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 5 October 2020 End date: 6 October 2020
Proposed changes to current services (if any):	Four dual-purpose beds were assessed as suitable for psychogeriatric beds within the secure unit. This reduces the number of dual-purpose beds to 11 and increase the number of psychogeriatric beds to 16. The total number of beds at the facility remain at 53.

Total beds occupied across all premises included in the audit on the first day of the audit: 49

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

Tasman Rest Home & Dementia Care provides rest home, hospital, dementia and psychogeriatric care for up to 53 residents. Occupancy on the days of audit was 49 residents. The service is divided into four smaller home-like care homes. Four dual-purpose beds have been reconfigured into the secure psychogeriatric home.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

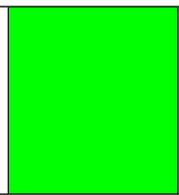
An operations manager and clinical manager manage the service on a day-to-day basis. The operations manager has been in the role for one year. The clinical manager has been in the role for four months and has previous aged care experience. The resident and families interviewed about the service all spoke positively about the care and support provided.

The audit identified that improvements are required around internal audits and meetings, first interRAI assessments and neurological observations.

The one previous finding from the certification audit around registered nurse staffing remains.

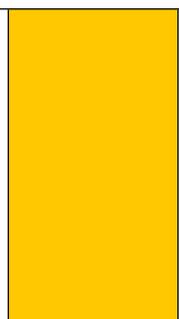
The service has continued the previous continuous improvement rating around the reduction of urinary tract infections.

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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Information about the Code of Rights the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and complaints process is readily available to residents and families. There is regular communication and support for families. Family are involved in the resident care plans and evaluations. Complaints processes are implemented, and complaints and concerns are actively managed and documented. A complaints register is maintained.

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 medium or high risk and/or unattained and of low risk.
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Services are planned and coordinated and are appropriate to the needs of the residents. Quality/risk goals are documented for the service with evidence of regular reviews. Quality data is collected and reported to head office for benchmarking. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is implemented and includes in-service education and competency assessments. There is sufficient care staff on duty to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses are responsible for each stage of provision of care including initial assessments, interRAI assessments, care plans and evaluations. Care plans reviewed were based on the interRAI outcomes and other assessments. Resident and relatives interviewed confirmed they were involved in the care planning and review process. There is at least a three-monthly resident review by the medical practitioner and psychogeriatric community nurse as required. There are regular visits and support provided by the community mental health team.

The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident. Individual activity plans have been developed in consultation with resident/family. There are regular entertainers and outings.

Medicines are stored and managed appropriately, in line with legislation and guidelines. The service uses an electronic medication system. Medication charts are reviewed at least three monthly.

Meals are provided from the main kitchen and delivered in insulated boxes to the home kitchenettes for serving. Resident's individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period. There is dietitian review and audit of the menus. All staff have been trained in food safety and hygiene.

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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The building has a current building warrant of fitness. There is a reactive and planned maintenance schedule. The environment is suitable for residents requiring rest home, hospital, dementia and psychogeriatric levels of care. Outdoor areas are safe and secure and accessible for the residents. There is adequate equipment for the safe delivery of care.

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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Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. There were four residents using restraints and no residents utilising enablers. Staff regularly receive education and training on restraint minimisation and de-escalation and disengagement.

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.

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

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Dementia Care NZ (DCNZ) facilities.

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	11	1	2	1	0	0
Criteria	1	36	1	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of complaints process. Information about complaints is provided on admission. Management operates an open-door policy. Interview with four relatives confirmed an understanding of the complaints process. There is an up-to-date online complaint register. There have been three internal complaints in 2019 and three internal complaints for 2020 to date. The operations manager and clinical manager share the management of complaints reporting process and outcomes to the quality systems manager and national clinical manager at the head office. All complaints were acknowledged within the required timeframe and letters of acknowledgement/investigation and resolution offered advocacy contact and details.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The clinical manager and three registered nurses (RNs) interviewed, confirmed family are kept informed. Four relatives (two hospital and two dementia care) stated they are notified promptly of any incidents/accidents or any changes to the resident health status. There was documented evidence of family notification recorded on the significant events record in each file including accidents/incidents, infections, general practitioner visits (GP), behavioural changes and medication. Fifteen incident and accident forms reviewed from August and September 2020 evidenced that family are notified following adverse events. Resident/family meetings encourage open discussion around the services provided. There is access to an interpreter service as required.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Tasman Rest Home & Dementia Care provides care for up to 53 residents. The service is divided into four home-like care units, with one 11-bed dual-purpose hospital/rest home unit (Ora home), one 16-bed psychogeriatric care unit (Aio home) and two separate dementia care units with 13 beds in the Ata Hapara home and 13 beds in the Rangi home. The service is in two separate buildings with a walkway between them. The hospital/rest home and psychogeriatric care homes are in one building and the two dementia care homes are in the other. At the time of the audit there were 49 residents in total. There were no rest home residents, 10 hospital residents and 24 dementia level of care residents all under the Aged Related Residential Contract (ARRC) and 15 residents in the psycho-geriatric care unit, all under the Aged Residential Hospital Specialised Services Contract (ARHSS) contract.</p> <p>Dementia Care NZ has a corporate structure in place which includes two directors and a governance team of managers (including a clinical advisor) and coordinators. The operations management leader and national clinical manager support the operations manager and the clinical manager respectively. They are also supported by a director who regularly visits the site, a quality systems manager and education coordinator who is based at the Tasman site. The director and educator were present on the days of audit. There is an overall strategic plan for 2018-2021 which is reviewed at least annually. A business plan is in place for all DCNZ facilities which includes a clinical focus around falls reduction, continence and pain management, monitoring of antipsychotropic medications and nutrition. The vision and values of the organisation underpin the philosophy of the service.</p> <p>An operations manager and a clinical manager oversee Tasman Rest Home & Dementia Care on a daily basis. The operations manager has been in the role since January 2020 and was previously in an administrative role for DCNZ. The operations manager had completed a general orientation and attended a two-day DCNZ operations manager professional development forum held by Zoom meetings due to Covid-19 restrictions.</p> <p>The clinical manager is responsible for the clinical oversight of the service and has been in the position since May 2020. She has had five years' work experience as an RN including community health, aged care and within a DHB setting. The clinical manager has completed a specific orientation to the role and attended a 2.5 professional development day for DCNZ clinical managers in September.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	PA Low	<p>The organisation-wide quality and risk management plan describes objectives, management controls and assigned responsibility. Quality goals around infection control, health and safety, Māori Health Plan and education link to the business plan. Progress with the quality and risk management plan is monitored through the monthly quality improvement meetings, however these have not been held as scheduled. There are monthly caregiver and RN clinical meetings that include discussion around quality data including infections, accidents/incidents, resident cares, restraint, policies, goals and objectives. Meeting minutes are maintained, and staff are expected to read the</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>minutes. Minutes sighted have included actions to achieve compliance where relevant. The service has policies and procedures to support service delivery which are reviewed at head office. Staff are informed of any policy reviews/changes.</p> <p>Data is collected on complaints, accidents, incidents, infection control and restraint use. Benchmarking with other DCNZ facilities occurs on data collected.</p> <p>There is a DCNZ audit schedule, however internal audits have not been completed as scheduled. There was no evidence of clinical audits completed as scheduled. Audits that have been completed do not identify a date or a signature. There were no corrective actions for audit outcomes less than expected.</p> <p>The 2019 enduring power of attorney (EPOA) survey was completed with a 44% response rate. Results indicated a high satisfaction rate of prompt notifications, approachable staff and respect for resident's privacy. In June 2019 a multidisciplinary service providers survey confirmed their satisfaction with the service provided at Tasman rest home and hospital.</p> <p>The service has an implemented health and safety management system. There are risk management, and health and safety policies and procedures in place including accident and hazard management register last reviewed November 2019. The director has overall responsibility for health and safety with the operations and clinical managers responsible for day-to-day environmental health and safety. Health and safety are discussed at facility meetings. The staff interviewed could describe the hazard reporting procedure.</p> <p>There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A physiotherapist is contracted for fortnightly visits and completes resident assessments, post falls assessments and staff safe manual handling and hoist training.</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</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. An online incident/accident register is maintained. Fifteen paper-based accident/incident forms for the month of August and September were reviewed in resident files. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at the clinical meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Neurological observations had not been completed as per protocol for seven resident falls reviewed for unwitnessed falls or with potential head injury (link 1.3.6.1).</p> <p>Discussions with the operations manager, clinical manager and national clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three Section 31 notifications made since the last audit. The service has provided information to the coroners in May 2019 and this case has not yet been closed. The service notified HealthCERT in April 2020 of a wandering person requiring police involvement. A Section 31 was completed for a norovirus outbreak in September 2019.</p>

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<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications and experience. Current practising certificates were sighted for the RN, GP and other allied health professionals involved in the service. Five staff files were reviewed (one clinical manager, one RN, two caregivers and one diversional therapist) and there was evidence that reference checks and police vetting were completed before employment. Annual staff appraisals were evident in all staff files reviewed for those who have been with the service over twelve months. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation was evidenced and staff could describe the orientation programme. Competencies are completed relevant to the roles.</p> <p>The in-service education programme for 2019 has been completed and the plan for 2020 is being implemented. Eight hours of staff development or in-service education has been provided annually. The education coordinator provided in-service via Zoom meetings and this was set up for staff from other DCNZ facilities to access. Staff have continued to attend sessions either on site or by Zoom, and their attendance recorded. The education coordinator is a registered psychiatric nurse and provides education specific for dementia and psychogeriatric levels of care including training around de-escalation and disengagement. The service uses the "Best Friends" approach to caring for residents, and staff complete an in-service education programme on this approach to care.</p> <p>Three of five RNs have achieved and maintained interRAI competency. There are 17 caregivers who work in the dementia homes and 12 who work in the psychogeriatric home who have achieved the required units for dementia care (under the ARRC) and psychogeriatric care (under the ARHSS). Four caregivers (two dementia care and two psychogeriatric) are currently completing their orientation before progressing through the required standards.</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>	PA Moderate	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Staffing rosters for each home were sighted and there are sufficient care staff on duty to meet the resident needs and resident safety on different shifts. Staff interviewed stated there were enough staff on duty and there was the flexibility to extend the short shifts if needed. Residents requiring a higher level of care are referred to the assessment agency for re-assessment. On the day of audit one dementia level of care resident had been transferred to the DHB assessment unit for reassessment of level of care.</p> <p>There is a full-time, plus on-call operations manager and clinical manager. There is a weekend manager. The DT rotates between the four units from 10 am to 1 pm Monday to Friday. There is an activity coordinator on duty in each home from 1.30 pm to 4.30 pm.</p> <p>Rangi and Ata Hapara: Each dementia home has a senior caregiver (home manager) on morning shift Monday to Sunday 7 am to 3 pm and a caregiver from 7 am to 1 pm. On afternoon shift there is a senior medication competent caregiver on duty 3 pm to 11 pm in each home; one caregiver in Ata Hapara from 4.30 pm to 8 pm and</p>

		<p>one home assistant in Rangji from 4.30 pm to 8 pm. There is a caregiver on night shift (11 pm to 7 am) in each home.</p> <p>Ora – rest home and hospital: There are two caregivers (one being medication competent) on the full morning and afternoon shifts (one finishes at 10 pm). There is one caregiver on the night shift from midnight until 8 am.</p> <p>Aio – psychogeriatric home: There are two caregivers (one being medication competent) on the full morning and afternoon shifts (one finishes at 10 pm). There is a morning home assistant from 8 am to 1pm and an afternoon home assistant from 4.30 pm to 8 pm. There is one caregiver on the night shift from midnight until 8 am.</p> <p>The service has an RN on duty 24 hours based in the PG unit who covers the residents in the hospital from 7 am to 11 pm. During the night shift the RN covers the hospital residents adjacent to the psychogeriatric home in the same building. There is an RN based in the dementia care homes from 8.30 am to 4.30 pm Monday to Sunday, who also oversees the hospital. The RN cover for the hospital does not meet the requirements of the ARCC. The previous finding around RN staffing remains.</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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicines are appropriately stored in both buildings. All staff that administer medicines have completed annual competencies and completed medication education. RNs administer medications in the dual-purpose rest home/hospital unit and psychogeriatric unit. Senior care staff administer medications for the dementia level care residents. The RN completes medication reconciliation for regular medications delivered in robotic packs and for the 'as required' medication delivered in blister packs. Medication reconciliation is recorded on the electronic medication system. There were no residents self-medicating. There were no standing orders or hospital stock. The medication fridge (in the dual-purpose rest home/hospital unit and psychogeriatric home) was monitored daily. The medication storage cupboards are monitored for room air temperature. Eyedrops in use were dated on opening.</p> <p>Twelve electronic medication charts were reviewed (four hospital, four dementia and four psychogeriatric). All medication charts had photo identification and allergy status noted. The outcomes of 'as required' medications is recorded in the electronic medication system. The GP reviews the medication charts at least three-monthly. Antipsychotic medication use is reviewed with input from the community mental health case manager who visits fortnightly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>All meals and baking at Tasman Rest Home and Dementia Care are cooked on site by two qualified cooks covering Monday to Sunday. A cook is on duty from 6.45 am to 5.15 pm daily and supported by a kitchenhand in the evening who completes cleaning duties. All staff have completed food safety including home assistants and care staff. There is a four-weekly winter/summer menu that is reviewed by a registered dietitian (2019). Special</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>diets accommodated are gluten free, dairy free, vegetarian and pureed meals. Meals are in dishes and are delivered in insulated boxes to the home kitchenettes where home assistants' plate and serve the meals. Dislikes are accommodated. Nutritious snacks are available 24 hours in the home kitchenettes including yoghurts, sandwiches, baking, ice-cream and fruit. The kitchen is accessible to staff afterhours.</p> <p>There is a current food control plan. A daily food control plan is completed that includes end cooked food temperatures, cooling, inward goods delivery, fridge, freezer and chiller temperatures and dishwasher rinse temperature. There is a separate cleaning schedule. Dry goods were date labelled. Perishable goods were date labelled. All goods were stored off the floor.</p> <p>The residents and family members interviewed were satisfied with the quality and variety of food served.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition changes the RN initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Relative notifications regarding resident changes in health is recorded on the significant events record held in each resident file. All care plans reviewed had interventions documented to meet the needs of the resident. Care plans are updated as residents' needs changed. Short-term care plans are used to guide staff for short-term needs and are reviewed regularly by the RNs.</p> <p>Wound assessment, wound management and evaluation forms were in place for the one wound present on the day of audit. The hospital resident had a wound on the ankle. The GP had reviewed the wound and made a referral to the wound nurse specialist at the DHB. There were no pressure injuries on the day of audit. There are sufficient pressure relieving resources available.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Monitoring forms are in use as applicable, such as bowel records, food and fluid charts, sleep charts, observation charts of resident "whereabouts", repositioning charts, weight, behaviour charts observations, pain and restraint monitoring. Neurological observations had not been completed as per protocol following unwitnessed falls.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are</p>	<p>FA</p>	<p>There is a lead diversional therapist (DT) who oversees a team of two DTs and five activity coordinators. The lead DT rotates between the four homes between 10 am to 1 pm. From 1.30 pm to 4.30 pm there is a DT or activity coordinator in each home seven days a week. Each home has a separate activity programme which is flexible, dependent on resident needs and choice of activity. Each home has a higher functioning resident advocate who provides suggestions for activities and outings. The weekly programme is displayed on noticeboards in all lounges. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. Care staff (interviewed) are also involved in individual activities with the residents. There are resource cupboards in each unit that are accessible to residents, staff and</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>families.</p> <p>Activities offered are meaningful and include sensory activities such as aromatherapy, pampering, cooking, fruit tasting, reminiscing, photos, memory boxes, barbeques, music therapy and sing-a-longs. Other activities include exercises, garden walks, lazy boy walks (hospital residents), movies, arts and crafts, poem readings, flower arranging, scrapbooking, colouring and garden picnics. Residents are involved in a number of clubs such as knitting club, cooking club, café club, gardening club and bowling club. The men's club enjoy trips to the recycling centre, card games, washing the vans and are planning a fishing trip. Homely activities include feeding the birds, folding serviettes, sorting/folding clothes, gardening and polishing cutlery. Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>Combined activities include church services, entertainment and visiting speakers which is held in the large hospital lounge. Residents from the dementia and psychogeriatric homes attend if appropriate and under supervision. There are weekly van outings for each home to places of interest and scenic drives. The DT has a current first aid certificate and drives the van accompanied by an activity coordinator. Community links involve visits to the local primary school, art festivals, garden centres, sing-a-longs in the park and to the older person mental health community hall for entertainment and activities. The service has supported Alzheimer's NZ with cuppa for a cause. Themes and events are celebrated.</p> <p>Residents have an activity assessment (My Profile) completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the DT activity plan is based on this assessment. Resident files reviewed identified that the individual activity plan and 24-hour multidisciplinary care plan is reviewed with the care plan review. Resident and family meetings are held. The resident and relatives interviewed were very happy with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Four of six files reviewed demonstrated that the long-term care plans reviewed had been evaluated by the RNs six monthly. Two residents had not been at the service long enough for a care plan evaluation. The care plans had been updated when changes to care occurs. Reassessments have been completed using interRAI LTCF for residents who have had a significant change in health status. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the RN, GP, DT and resident/family. If the family are unable to attend, the RNs contacts the relative for input into the care plan.</p> <p>The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2:</p>	<p>FA</p>	<p>There are two separate buildings with a current building warrant of fitness. General maintenance is managed by</p>

<p>Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>the operations manager. There is a scheduled maintenance plan in place. Contractors are contacted when required. The DCNZ company employ a tester and tagger for electrical equipment. There is a company painter for continual refurbishments of rooms and communal areas. There is a carpet replacement plan for the rest home/hospital lounge, hallways and bedrooms. The hot water temperatures checked weekly, were recorded at 45 degrees Celsius or below in all resident areas. Contractors maintain the gardens and grounds.</p> <p>Four dual-purpose rooms have been reconfigured into the psychogeriatric home. The internal secure doors were shifted to accommodate the additional four rooms which were assessed as suitable for psychogeriatric level of care. There is easy access to the outdoors from each unit. The courtyards and gardens are well maintained with safe paving, outdoor shaded seating and gardens. The residents in the dementia and psychogeriatric units can access secure outdoor areas.</p> <p>Interviews with the RNs and the caregivers confirmed that there was adequate equipment to carry out the cares according to the residents' care plans.</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>	CI	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms, and short-term care plans are completed for all resident infections. Infections are collated in a monthly register and a monthly report is completed by the infection control coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the staff meetings and to head office. Benchmarking occurs against other Dementia Care New Zealand facilities. The service has continued to reduce urinary tract infections (UTI) by more than the 10% documented in the infection control goal around UTIs.</p> <p>There has been one norovirus outbreak in September 2019. The Public Health unit and MOH were notified.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with caregivers and nursing staff confirmed their understanding of restraints and enablers. There were no residents using enablers and four residents using restraint in the psychogeriatric home (one H belt and three arm restraints). When a resident requires two staff members to gently hold their hands to calm the resident and allow another staff member to provide essential cares, this is documented as 'arm restraint' and is only used after a full restraint assessment, discussion with the family and involvement of the GP. Each resident has a restraint care plan and monitoring form. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	The quality improvement meeting is scheduled for the third Wednesday of every month, however there are no records of meeting minutes for 2020. There is a DCNZ internal audit schedule in place, however these have not been completed as per schedule.	1) There is no evidence of monthly quality improvement meetings occurring, therefore the monitoring of the quality system is not being followed up by the service and 2) facility and clinical audits have been completed, but not all completed as scheduled. Audits that have been completed have not been dated and do not always identify the auditor. There are no corrective actions completed for audit results less than expected and there is no audit follow-up or reporting evident.	1) Ensure quality improvement meetings are held as scheduled and 2) ensure internal audits are completed as scheduled, corrective actions are completed, results discussed, followed up and reported.

				90 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>There is an RN based in the 16-bed psychogeriatric unit 24/7 which is attached to the 11 bed dual-purpose rest home/hospital unit. The psychogeriatric unit and rest home/hospital are in the same building in very close proximity. There is no RN rostered on duty in the dual-purpose unit from 7 am to 10 pm, however the RN in the dementia units oversees the hospital unit. There is an RN on duty in the dementia care homes from 8.30 am to 4.30 pm. Registered nurse staffing does not meet the ARRC for hospital level of care. The RN staffing in the psychogeriatric home meets the requirements under the ARHSS contract.</p>	<p>There is one RN rostered over 24 hours a day and located in the psychogeriatric home. The contract with the local DHB states that the psychogeriatric unit and hospital unit can share a RN between 10 pm and 7 am only if the service is under 50 residents. However, there is no RN rostered over the hospital unit between 4.30 pm and 10 pm. There has been correspondence and discussion between the DHB contract manager and director (interviewed) in regard to the RN staffing status.</p>	<p>Ensure RN covers meet the requirements of the ARHSS contract.</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Negligible</p>	<p>First interRAI and routine interRAI assessments had been completed in four of the long-term resident files reviewed. There were two residents (one dementia care and one psychogeriatric care) who were admitted during the Covid-19 restriction levels who did not have an interRAI assessment completed within 21 days of admission.</p>	<p>InterRAI assessment did not get completed for two residents (one dementia care and one psychogeriatric care) admitted during the Covid-19 restriction levels. At the same time there were two interRAI trained RNs who left the service (one on maternity leave and one to relocate to another region). This left two RNs who are interRAI trained. The clinical manager and two RNs have been waiting to complete online interRAI training.</p>	<p>Ensure first interRAI assessments are completed within 21 days of admission.</p> <p>90 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Neurological observations are required following unwitnessed falls or where there is a potential for head injury. Seven incidents of unwitnessed falls had neurological observations commenced however these had not been completed as per protocol.</p>	<p>Neurological observations post unwitnessed falls for seven residents were not completed as per the protocol. Observations had not always been completed during the night and documented the resident as asleep. There was no documentation in progress notes where neurological observations had not been completed.</p>	<p>Ensure neurological observations are completed as per protocol and record the reason for discontinuing observations earlier than the required timeframe of 24 hours.</p> <p>90 days</p>
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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 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>The infection control plan included a continuing reduction of UTIs across all levels of care by 10%. All urinary tract infections are collated on a monthly basis and reported to head office for benchmarking against similar sized facilities and levels of care. Tasman rest home and dementia care UTI rates have continued below the organisational target range.</p>	<p>The service has continued to implement strategies around reducing the incidents of urinary tract infections (UTIs) that included: (a) education on the importance of hydration, (b) education sessions on infection control including hand hygiene, resident personal hygiene and perineal cares, continence management and UTIs (c) extra fluid rounds in warmer weather (d) promoting and implementing toileting regimes that meets individual resident’s needs and (e) cranberry juice and daily yoghurt for residents prone to UTIs. As a result of the strategies implemented, the facility has remained below the organisational target range of 1.51 UTIs per 1000 bed nights for hospital level care, 0.01 psychogeriatric level of care and 1.36 dementia level care over 2019 and 2020 to date. A six-monthly analysis for June to December 2019 identified seven UTIs across all levels of care. In the last six-month period from January 2020 to June 2020 there were zero UTIs. The service has continued to exceed the standard.</p>

End of the report.