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

## Introduction

This report records the results of a Partial Provisional Audit; 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 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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: 17 November 2021 End date: 18 November 2021

**Proposed changes to current services (if any):** The service is reconfiguring their rest home/hospital unit of 11 beds to an 11-bed psychogeriatric unit. A plan is in place to reassess current residents and to gradually cease providing hospital level care. With the reconfiguration (and once the current hospital residents are reassessed or transferred) the service will discontinue providing hospital and rest home level care and will continue only providing Hospital - Psychogeriatric services and dementia level care. Total bed numbers will remain the same at 53 beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 43

# 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.

## General overview of the audit

Tasman Rest Home and Dementia Care is part of the Dementia Care New Zealand (DCNZ) group. Tasman Rest Home and Dementia Care provides hospital, dementia, and psychogeriatric care for up to 53 residents. On the day of audit there were 43 residents.

This certification audit was conducted against the 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 family, management, and staff.

A partial provisional audit was also conducted in conjunction with the certification audit to verify suitability for the reconfiguration of the existing 11 hospital/rest home beds to psychogeriatric beds.

An operations manager, (non-clinical) and clinical manager (registered nurse), manage the service on a day-to-day basis. The operations manager has been in her role since December 2020 and has had previous experience working in aged care. The clinical manager was previously employed as a registered nurse in aged care and covered the acting clinical manager role prior to being employed permanently in January 2021. They are supported by registered nurses including the DCNZ education coordinator (a trained psychiatric nurse), four home managers (senior caregivers) and a team of experienced staff. The team is supported by an organisational management team from DCNZ.

The resident and families interviewed all spoke positively about the care and support provided.

The certification audit identified no shortfalls.

The partial provisional audit identified shortfalls around documenting a draft roster and securing the reconfigured psychogeriatric unit.

## Consumer rights

Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy, and informed consent. The service provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice.

The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented, and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

## Organisational management

Tasman Rest Home and Dementia Care implements a quality and risk management system that supports the provision of clinical care. The quality management system includes standard meetings, and monthly infection control, health and safety, resident incident and quality meetings. An annual resident/EPOA satisfaction survey is completed, and resident meetings are held. There is a health/safety and risk management programme in place.

There are human resources policies including recruitment, selection, orientation and staff training and development. An education and training plan is implemented and includes in-service education and competency assessments. Registered nursing cover is provided twenty-four hours a day, seven days a week. The staffing policy aligns with contractual requirements.

## Continuum of service delivery

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 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 bi-annual audit of the menus. All staff have been trained in food safety and hygiene.

## Safe and appropriate environment

The building has a current building warrant of fitness. There is a reactive and planned maintenance schedule. There is adequate equipment for the safe delivery of care.

There are two separate buildings. There is a short open walkway between the two building entrances. All resident rooms are single within the facility. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a spacious lounge and dining area in each home within the facility, and smaller lounges available for quieter activities or visitors. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. The internal areas are ventilated and heated. There is wheelchair access to all areas. The outdoor areas are safe, easily accessible, and secure.

All equipment is well maintained. All chemicals are stored safely. There are emergency policies and procedures documented.

## Restraint minimisation and safe practice

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. A register is maintained by the restraint coordinator/registered nurse. Residents using restraints are reviewed monthly in the registered nurses meeting. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

## Infection prevention and control

There is a suite of infection control policies and guidelines available to support practice. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical manager) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual training provided internally and has access to external training provided by the local DHB.

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. There have been no outbreaks since the previous audit. A Covid-19 resource folder is in place, training around hand hygiene and donning and doffing of personal protective equipment has been completed and adequate supplies of personal protective equipment was sighted during the audit.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Interviews were held with the management team (the managing director, the national clinical manager, the facility operations manager, the facility clinical manager [registered nurse] the education coordinator [registered nurse], and staff 13 caregivers [including one health and safety representative and two home assistants], one registered nurse, two diversional therapists and two activities coordinators [one home assistant] one cook and one kitchen hand) and all confirmed their familiarity with the Code.  Training around the Code, advocacy, informed consent, privacy, and elderly abuse are part of the mandatory training that staff undertake. These are offered during the year and staff are required to attend one session. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent and advanced directives policies/procedures. General consent is obtained for collection, storage, release, access and sharing of information. Consent for photographs to be taken for identification and public display and consent for outings. There is documented evidence of discussion with the resident or enduring power of attorney (EPOA) where the general practitioner (GP) has made a medically indicated not for resuscitation status. All files reviewed of residents in the secure units (two dementia and two psychogeriatric), had copies of the EPOA activation on file. Copies of the resident’s advance directive where applicable, is on file. Care plans and 24-hour activities care plans demonstrate resident choice as appropriate. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and relatives are provided with a copy of the Code and Advocacy pamphlets on entry. Interviews with the management team confirmed practice. Relatives interviewed confirmed that they are aware of their right to access advocacy. Discussions with relatives confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files included information on residents’ family/whānau and chosen social networks. Staff receive education and training on the role of advocacy services. The nationwide advocate visits the service annually and as required. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Following Covid-19 lockdown periods and level restrictions, volunteers and school groups who previously visited the residents, have reduced, and the schools are not yet able to come and visit residents. Entertainers are back visiting under the current level 2 restrictions. Visiting is limited and by appointment only. A van is used for resident outings.  One of the younger residents is involved in a community craft group. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice. The management team leads the investigation and management of complaints (verbal and written). There is a complaint (and compliments) log/register that records all correspondence and resolution of complaints. Complaints are discussed at the monthly quality meetings. Complaints forms are visible around the facility on noticeboards.  All verbal and written complaints are recorded, investigated, and treated seriously. There were 14 complaints logged to date in 2021 year to date and a further complaint in 2020 since the previous audit. The complaints reviewed during the audit confirmed that these had been responded to, investigated, and closed out in a timely manner with the complainant offered advocacy services should they not be satisfied with the outcome. One complaint was received through the district health board (DHB). The complaint was resolved, and all actions have been implemented.  Discussion with residents and relatives confirmed they are aware of how to make a complaint. A complaints procedure is provided to residents or EPOA within the welcome pack at entry. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There are posters of the Code on display throughout both buildings. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the clinical manager discusses the information pack with the resident and the family/whānau. The information pack incudes a copy of the Code.  Interviews were held with one hospital resident, and seven family members (four psychogeriatric, and three dementia). All confirmed the services being provided are in line with the Code. Other family members from the dementia unit were not able to be contacted on the day of audit however observations showed that practice was in line with the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and relatives interviewed were positive about the service in relation to the resident’s values and beliefs being considered and met. Resident files and care plans identified residents' preferred names. Caregivers were observed to knock on doors before entering resident bedrooms. Care staff confirmed they promote the residents' independence by encouraging them to be as active as possible. The resident and relatives interviewed during the audit confirmed that the residents’ privacy is respected.  The residents’ personal belongings are used to decorate their rooms as observed on the day of audit.  Resident’s cultural, social, religious, and spiritual beliefs are identified on admission and included in the resident’s care plan/activity plan, to ensure the resident receives services that are acceptable to the resident/relatives. Information around values and beliefs is gathered on admission with family involvement and is integrated into the residents' care plans. Training around privacy and dignity has been provided annually along with the code of rights training. The EPOA survey 2021 results evidenced 63.6% of respondents felt residents were treated with privacy and dignity, a further 36% were satisfied.  There is a policy around abuse and neglect. Staff receive training around abuse and neglect. Care staff interviewed are able to discuss ways in which they would recognise and manage suspected abuse or neglect. Staff, managers, and the general practitioner (GP) interviewed confirmed that there is no evidence of any abuse or neglect. Residents are supported to attend church services of their choice and are offered spiritual services weekly/monthly. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe practices for Māori. The service has as a quick reference flip chart (Tikanga Recommended Best Practice Standards/Guidelines) in place that provides guidance for staff on culturally acceptable practice.  Family/whānau involvement is encouraged in assessment and care planning, and visiting is encouraged. The service has a cultural advisor who is available to provide assistance and guidance. There were two residents who identified as Māori, and both had Māori care plans in place. The EPOA 2021 satisfaction survey evidenced 63% of respondents were very satisfied with cultural and spiritual beliefs of the residents being upheld and a further 36% were satisfied. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The resident and family are invited to be involved in care planning. It is at this time that any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled and occur to assess if needs are being met. Family are invited to attend. Discussions with relatives inform that values and beliefs are considered. The relatives and resident interviewed confirmed that staff consider their culture and values. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff described implementation of policies and processes relating to identifying and the prevention of discrimination, abuse and neglect, harassment, and exploitation. Training includes discussion of the staff standards of conduct and prevention of inappropriate care. Staff interviewed stated that they were aware of the policies and were active in identifying any issues that relate to the policy.  Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the staff files sampled. Staff comply with confidentiality and the house rules. The house rules provided to staff at employment includes standards of conduct. Staff have had training around professional boundaries in 2021.  Residents and the family members interviewed stated that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination or exploitation. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Policies and procedures are reviewed on a regular basis and are in line with current best practice and legislation. The service strives to create a homely resident-focused environment for residents in each of the homes. There is good support from the mental health services and GP. Staff are encouraged to complete New Zealand Qualification Authority (NZQA) unit standards through the Careerforce programme. the education coordinator is a Careerforce assessor for the service.  The education coordinator sets the education planner across the organisation. The annual planner includes regular dementia and de-escalation training. This includes ‘best friends approach to care’, which includes de-escalation techniques and teaches staff around body language and creating calm. The management team, registered nurses and the diversional therapy team are supported to attend external training. There are high numbers of staff who attend education sessions or complete self- directed learning packages if not able to attend compulsory training sessions.  The service benchmarks internally with all nine facilities in the DCNZ group, and have recently implemented an electronic resident management system, which will also be utilised to collate and analyse monthly data. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Of the electronic incident forms reviewed, all identified that family were notified following a resident incident. Interviews with relatives, caregivers, and the RN confirmed that family are kept informed.  Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | 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 43 residents in total. Nine hospital residents including one resident funded through ‘close in interest’. Fourteen residents in the PG unit (12 were funded under the Aged Residential Hospital Specialised Services Contract (ARHSS) contract, one resident was funded under long term support- chronic health contract (LTS-CHC), and the other under the ‘close in interest’ contract, and there were 20 dementia level residents including two residents funded through ‘close in interest’ funding. There were no residents at rest home level care.  A partial provisional audit was held in conjunction with the certification audit as the service plans to reconfigure the existing 11 hospital/rest home level beds to psychogeriatric beds. A request for reconfiguration has been sent to the Ministry of Health. The rooms were verified as suitable to provide psychogeriatric level of care.  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 regional clinical manager and national clinical manager support the clinical manager. 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, national clinical manager and education coordinator were present on the days of audit. A business plan is in place for all DCNZ facilities which includes a clinical focus and includes ongoing refurbishments, staff retention and recruitment. The vision and values of the organisation underpin the philosophy and have recently been reviewed and updated. The managing director has provided training sessions on the revised vision and values.  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 December 2020 and has previous experience working in aged care and held health and safety role for DCNZ at a sister site. The operations manager had completed orientation and attended a two-day DCNZ operations manager professional development forum held in Christchurch. . The operations manager is supported by the DCNZ operations management leader. The clinical manager has been in the acting clinical manager role since January before being appointed in the permanent role in March 2021. She has had experience as an RN in aged care. There is onsite support from the RN team, DCNZ education coordinator, who is a trained psychiatric nurse with a current practicing certificate, and three home managers (experienced caregivers with more than five years’ experience each). One of the directors visits the site on a regular basis to support the management team. The clinical manager has completed orientation to the role and attended a two-day professional development day for DCNZ clinical managers.  Partial provisional:  A letter from Nelson Marlborough District Health Board (NMDHB) dated 30 August 2021 is supportive of the increase in psychogeriatric (PG) beds. They have discussed this with the GP and older peoples mental health services (OPMH) who are also supportive.  A plan is in place to reassess current residents and to gradually cease providing hospital level care. This will be done be completing interRAI and other assessments to determine appropriate level of care. The service has been working with the DHB to develop a plan around reassessment and placement of residents.  There is a documented transition plan around changing service levels. There will be no changes required to the current food services, cleaning, and laundry services as a result of the proposed reconfiguration. The service has not yet decided on a planned date of opening. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the temporary absence of the clinical manager, a senior RN would be first on call. The clinical manager at a sister facility is second on call and is available by phone. The education coordinator (RN) is available to support the RNs. The clinical manager is supported by the regional clinical manager and the national clinical manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation-wide quality and risk management plan describes objectives, management controls and assigned responsibility. Quality goals around infection control, health and safety, and education link to the business plan. Progress with the quality and risk management plan is monitored through the monthly quality improvement meetings. Meeting minutes are maintained, and staff are expected to read the minutes which are kept in a folder in the staffroom, a communication book informs staff of day to day information. There are monthly quality meetings which staff are invited to attend. Minutes reviewed included discussion around quality data including infections, accidents/incidents, resident cares, restraint, policies, goals, and objectives. Staff who do not attend have the opportunity to read the meeting minutes. Meeting minutes reviewed 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.  Data is collected on complaints, accidents, incidents, infection control and restraint use. Benchmarking with other DCNZ facilities occurs on data collected.  There is a Dementia Care New Zealand (DCNZ) internal audit schedule, which is maintained. Clinical and environmental audits are completed as scheduled, and corrective actions are completed for audit outcomes less than expected. Corrective actions are documented on an electronic system, all corrective actions have been signed off once completed.  Annual enduring power of attorney (EPOA) satisfaction surveys are conducted. Results indicated a high satisfaction rate of input into resident care and decision making, being informed promptly of changes, and privacy and dignity being upheld. Almost 90% of respondents were satisfied with staff and accessible management team.  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. A current hazard register is in place, which is reviewed regularly. 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. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Incident/accident data has been collected and analysed. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made (link 1.2.3.6). Incident forms are completed electronically by care staff and the resident is reviewed by the RN at the time of event. A review of 15 electronic incident reports evidenced neurological observations had been completed for unwitnessed falls, wound charts were implemented for skin tears and the mental health team were involved in residents care for challenging behaviours. Opportunities to minimise future incidents (where possible) were identified.  Interview with staff informed incidents/accidents are reported appropriately. Discussions with management, confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. Notifications were made to HealthCERT since the last audit for changes in management, three absconding residents and one unstageable pressure injury. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resources policies to support recruitment practices. Seven staff files were reviewed (the clinical manager, one RN, one diversional therapist, and four caregivers). All had relevant documentation relating to employment including reference checks, a police check, job description and signed contract relevant to their role. A list of practising certificates is maintained, and performance appraisals were current in all staff files reviewed.  The service has an education coordinator who is responsible for ensuring the orientation programme is completed for new staff. There is a buddy system for new staff and staff interviewed stated that they had completed a robust orientation. The six-week orientation process includes introduction to the facility, role of the caregiver, aging process, dementia and restraint, consumer safety and awareness, and the environment. Training also includes compulsory education sessions required to be completed.  There is a yearly organisational education plan that includes all required education as part of these standards. The plan is coordinated by the education coordinator (RN). Staff are able to make suggestions on additional topics for inclusion in the in-service calendar. Training attendance is recorded on a database (sighted), and the education coordinator undertakes a reconciliation of attendance annually. This process ensures staff are meeting compulsory requirements and from the information reviewed all staff have attended all compulsory training within the last year. The organisation run a series of three ‘Best Friends approach to care’ training sessions which train staff around body language, and effective de-escalation techniques to calm challenging behaviour, and includes dementia training. Competencies are completed and a record of completion is maintained in the database. DCNZ assists the activities team to attend the annual DT conference  There is evidence on RN staff files of attendance at the RN training day/s and external training. All staff administering medications had a current medication competency in place, and there is at least one staff member in each unit with a current first aid certificate throughout all shifts.  Staff are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications. There are a total of 39 caregivers. Twenty-four staff who work in the PG and dementia units have completed the required dementia unit standards, four are in the process of completing and one staff member has been recently employed. The education coordinator is working with the ten caregivers who have not yet completed, to ensure they have completed the required dementia level standards prior to opening the new PG unit.  Partial provisional:  The existing staff will continue to be employed. There are a number of staff who work in the existing hospital unit who already provide cover in the PG and dementia unit and have already completed the required dementia standards. There is a plan being implemented to train the hospital staff who have not completed the dementia standards to complete this within required timeframes. It is proposed there will be a mix of experienced and less experienced staff allocated on each shift. Five out of 12 staff from the existing hospital unit already cover shifts in the PG unit, the rest cover in the dementia units. Current staff are already orientated to the unit. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low | 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 needs assessment service coordination (NASC) 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.  There is a full-time operations manager and clinical manager who are on call after hours. Registered nurses work 12 hour shifts from 6.45 am to 7.15 pm and 7 pm to 7 am and are based in the hospital building. The activities team share their time between the units from 1.30 pm to 4.30 pm across seven days a week.  Rangi (nine residents) and Ata Hapara (11 residents): 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 pm to 8 pm and one caregiver in Rangi from 4.30 pm to 8 pm. There is a caregiver on night shift (11 pm to 7 am) in each home.  Ora – hospital/rest home (nine residents): There are two caregivers (one being medication competent) on morning and afternoon shifts one from 7 am to 3 pm and one home assistant from 8 am to 1 pm. The afternoon shift has one caregiver from 3 pm to 12 midnight, one caregiver from 4.30 pm to 9 pm and a home assistant from 4.30 pm to 8 pm. There is one caregiver on the night shift from midnight until 8 am.  Aio – psychogeriatric unit (14 residents): 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 1 pm 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.  Partial provisional:  There is no documented plan/draft roster around staffing for the proposed PG unit. Management described utilising a mix of experienced and less experienced staff throughout the shifts. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s electronic file. Residents' files medication charts and all devices are password protected from unauthorised access. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.  Entries in electronic records are legible, dated and signed by the relevant care staff with log on details. Individual resident files demonstrate service integration. Members of the multi-disciplinary team either documented consultation notes in the residents electronic file, or the consultation note is scanned onto the system. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are pre-entry and admission procedures in place. Residents are assessed prior to entry by the needs assessment coordinators and where required the psychogeriatric team. The clinical manager liaises closely with the assessing teams to ensure the service can meet the assessed needs of the resident. The service has an information booklet for residents/families at entry. It is designed so it can be read with ease (spaced and larger print). Family members interviewed stated they received sufficient information on the services provided and are appreciative of the staff support during the admission process. Admission agreements reviewed in seven files align with the ARRC and ARHSS contract. Admission agreements had been signed in a timely manner. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service has a policy that describes guidelines for death, discharge, transfer, documentation, and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. Transfer notes and discharge information was available in resident records of those with previous hospital admissions. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | 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 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. Regular medication internal audits are completed, medication errors are documented on an incident form. If required, staff are required to complete a reassessment of their medication competency.  There were no residents self-medicating. There were no standing orders or hospital stock. The medication fridge temperature (in the hospital unit and psychogeriatric unit) has been monitored daily. The medication storage cupboards are monitored for room air temperature. Eyedrops in use were dated on opening stored in both medication trolleys.  Fourteen electronic medication charts were reviewed (six 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 nurse, GP, and pharmacist.  Partial provisional:  There are no proposed changes to the medication rooms or location of the nurse’s station. There are an adequate number of staff with medication competencies for medication administration and second checker competencies. The registered nurses will continue to administer medications with a medication competent caregiver as second checker when required. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The kitchen is situated in the psychogeriatric wing. The kitchen is secure and can only be accessible by keypad. All meals and baking are done 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 (September 2021). Special diets accommodated are gluten free, dairy free, vegetarian, and pureed meals. Cultural and spiritual needs are met. There were adequate fluids sighted in the kitchenette fridges and supplement protein drinks are available.  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.  There is a current food control plan. The food control plan is verified and expires 5 April 2022. A daily food safety 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 and appropriately stored. Perishable goods were date labelled.  Lunch was observed in the hospital and psychogeriatric unit. There were sufficient staff available to assist residents with their meals. There was sufficient space for seating for staff, mobility equipment and residents to move around. Special utensils are available in both kitchenettes.  The residents and family members interviewed were satisfied with the quality and variety of food served.  Partial provisional:  There are no proposed changes to the dining room or kitchen when the reconfiguration of the hospital to psychogeriatric beds takes place. Each have their own dining room and kitchenette and food is transported in hotboxes to each kitchenette, plated and served by caregivers and home assistants. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The reason for declining service entry to potential residents is recorded should this occur and communicated to the potential resident (as appropriate)/family. The clinical manager reported that the referring agency would be advised when a resident is declined access to the service. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | An RN completes an initial assessment and care plan on admission, including a range of paper based clinical risk assessment and relevant risk assessment tools. Risk assessments are completed six-monthly. The interRAI assessment is completed in files reviewed. The outcomes of assessments form the basis of the long-term care plan.  Changes in any assessment’s outcome scores are updated in the care plans. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Seven resident files sampled all included a care plan and demonstrated service integration and input from allied health. There was evidence of resident (where able) and family consultation in the care planning process. Short-term care plans were in use for changes in health status. Resident care plans reviewed were resident-centred and document the required support needs in sufficient detail. Residents with challenging behaviours had triggers (where they could be identified), a description of behaviour, and individualised de-escalation techniques documented. Activities assessments and plans were in place for all resident files reviewed. Care plans include medical conditions and medication management.  Care plans reviewed demonstrated service integration and input from allied health. InterRAI assessments informed the care plans and care plans reflect the required support needs. A range of specialist care professionals, including, Nurse Maude specialists, mental health services for older people, physiotherapy and podiatry support are available for support. Assessments and care plans reviewed included input from allied health professionals. The resident and relatives interviewed confirmed they were happy with the delivery of care. Caregivers interviewed reported they found the care plans easy to follow and contain information to provide quality care for residents. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | 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. Paper based short-term care plans are used to guide staff for short-term needs and are reviewed regularly by the RNs.  Wound assessment, wound management and evaluation documentation were in place for the four wounds present on the day of audit. Two hospital residents had pressure injuries recorded (one facility stage three and one non-facility acquired unstageable). The required notification on section 31 documentation were completed at the time. The nurse specialist at the DHB reviewed the wounds however ongoing monitoring and dressings are done by the RNs. There was evidence that pressure injuries are progressing towards healing. There are sufficient pressure relieving resources and wound dressing stock available.  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.  Monitoring forms are in use as applicable, such as bowel records, food and fluid charts, sleep charts, observation charts, repositioning charts, weight, behaviour charts observations, pain, and restraint monitoring. Neurological observations had been completed as per protocol following unwitnessed falls. |
| Standard 1.3.7: Planned Activities  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. | FA | There is a lead diversional therapist (DT) who oversees a team of one DT 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 families.  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, men’s club, cooking club, café club, gardening club and bowling club. The men’s club enjoy, card games and board games. Homely activities include feeding the birds, folding serviettes, sorting/folding clothes and socks, 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.  Combined activities include church services and entertainment is held in the lounge of Ata Hapara. Residents from the dementia and psychogeriatric homes attend if appropriate and under supervision. On the day of the audit there were combined activities and include a sing-along, baking and ukulele player. There are reminiscence boards on walls in common areas.  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 Māori heritage site, garden centres, sing-a-longs in the park and to the older person mental health community hall for entertainment and activities (when permitted within Covid-19 restrictions). The service has supported Alzheimer’s NZ with cuppa for a cause. Themes and events are celebrated and include Matariki, cultural events, Anzac Day, and Melbourne Cup.  Residents have an activity assessment (about me and my lifestyle) 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 activities care plan is reviewed with the care plan review. Resident and family meetings are held. There is a relative support meeting monthly where relatives support one another and receive information to understand dementia. The resident and relatives interviewed were happy with the activities offered. The EPOA survey responses related to satisfaction with activities were satisfactory for 2020 and 2021.  Partial provisional:  The activities programme is established and includes activities suitable for residents requiring psychogeriatric level of care. The draft activities programme follows a similar format as for Aio (existing PG) wing. Activities include reminiscing, sensory and tactile activities suitable for residents with dementia. A qualified DT is involved in the planning of the programme and is also allocated to the unit to assist with the development of 24-hour behaviour plans for residents. There are no changes planned to the times of delivering of the programme. All activity coordinators have completed the dementia standards. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Registered nurses evaluate initial care plans. Files sampled demonstrated that the long-term nursing care plan were evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Evaluations reviewed documented progress toward meeting the goals. Changes to resident health status is updated in the care plans. Residents (where appropriate) and the relative interviewed stated they were involved in care planning reviews or were informed of changes made. The family members interviewed confirmed that they are informed of any changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where a resident’s condition had changed, and the resident was referred for reassessment for a higher level of care. Discussion with the clinical manager and RNs identified that the service has access to a wide range of support either through the GP, nurse specialists, hospice, older persons mental health team and contracted allied professionals. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets are available.  Partial provisional:  The current practice of waste management will continue. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | There are two separate buildings. One building accommodates 26 dementia level care beds (Ata Hapara and Rangi units each with 13 beds) and the second building accommodates 11 hospital/rest home level beds and 16 psychogeriatric beds. There is a short open walkway between the two building entrances.  There are four units, Aio (PG), Ora (currently hospital/rest home but is the proposed new PG unit), Ata Hapara and Rangi (both dementia units) that provide care services for up to 53 residents. Each unit has its own kitchenette, dishwasher, microwave, fridge, and oven, open plan dining and lounge areas. Furniture and fittings are appropriate for the age group. All areas have enough space and seating to provide for individual and group activities. The home has a current building warrant of fitness, which expires on 5 July 2022.  General maintenance is managed by the operations manager. There is a scheduled maintenance plan in place. Contractors are contacted when required. The operations manager oversees the maintenance programme and is supported by the national procurement manager.  Medical equipment has been checked and calibrated. All power points are connected to residual current device (RCD) this is checked six-monthly. An environmental safety audit is completed six monthly and includes monthly hot water temperature monitoring.  Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors from each unit. The interior courtyards and gardens are well maintained with safe paving, raised gardens, outdoor shaded seating, lawn, and gardens.  The residents in the dementia and psychogeriatric units can access secure outdoor areas. Interviews with the RNs and the caregivers confirmed that there was adequate equipment to carry out the cares according to the residents’ care plans.  There is a nurse’s station/office and medication cupboard, safe and secure storage of resident files safes in each building.  The kitchen and laundry is located in the psychogeriatric unit - both locked and secure.  Partial Provisional audit:  Ora (current hospital/rest home) wing (11 beds) and Aio (current PG) has 16 beds are located in the same building and will both accommodate psychogeriatric residents. This will increase the psychogeriatric beds to 27 beds. The total number of certified beds remain the same. The door between the psychogeriatric unit and the hospital/rest home unit is currently secure. Advised that the secure door between both units will be removed as the PG unit will be run as one unit.  There is a safe level access from Aio wing to an internal courtyard. There is a ramp access to the entry door. Ora wing has access to an outdoor space adjacent to the carpark which will need to be secure prior to occupancy. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are an adequate number of toilets and shower/bathing areas for residents, and separate toilets for staff and visitors. Most rooms have ensuites and some bedrooms have shared ensuites. Other residents share communal toilets and showers. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.  All handbasins, toilets and communal showers have flowing soap, hand sanitiser and paper towels. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices.  Partial provisional:  Ora wing has eight rooms with ensuite toilet, basin, and shower and three with handbasins. There are further changes proposed. There are sufficient bathroom and toilet facilities for the change in level of care. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. All bedroom doors are wide to accommodate ease of entry and exit of ambulance transfer equipment.  Partial provisional:  The current bedrooms are sufficient to accommodate psychogeriatric level of care. There are no proposed changes to bedrooms when the hospital beds change to psychogeriatric beds. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are large communal lounges and dining areas in each unit. There are also smaller sitting areas for residents and families to access. Communal areas in each unit are used for activities, recreation, and dining activities. All dining rooms are spacious and located directly off the kitchen/servery area. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit.  Provisional audit:  There are no immediate proposed changes to the lounge/dining and kitchenette in Ora wing. The units will remain the same with a lounge and dining area each, each unit will have allocated staff (as per current roster) to provide assistance and supervision of meals (link 1.2.8.1). |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All linen and personal clothing is laundered on site. Adequate linen supplies were sighted. The cleaning cupboard containing chemicals is locked. All chemicals have manufacturer labels and safety data sheets available. The cleaning trolley is well equipped and stored in a locked area when not in use. Cleaning staff were observed to be wearing appropriate personal protective equipment. The resident environment on the day of audit was clean and tidy in all areas. The one resident interviewed was satisfied with the cleanliness of the communal areas and her bedroom.  Laundry duties are done by caregivers in Aio wing. One caregiver interviewed confirmed there is an established process of when laundry duties are done and sufficient time is allocated for these duties. The laundry is secure and only accessible by keypad.  There is a secure sluice room located next to the laundry with protective eyewear, gloves, and aprons for use. Laundry equipment, temperatures and dispensing liquids are maintained by an external contractor. There is a laundry manual located in the laundry.  The entry and exit doors are kept secure.  Partial provisional:  There are no proposed changes to the management of cleaning and laundry as the bed numbers will remain the same. The service is adequate to accommodate the reconfiguration of beds. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. There are adequate supplies in the event of a civil defence emergency including sufficient food, water (header tanks), blankets and alternate gas cooking, BBQ and gas hobs in the kitchen, and there is access to a generator if required. There are civil defence supplies and first aid kits centrally located and easily accessible. Emergency equipment is available at the facility. Short-term backup power for emergency lighting is in place.  A fire evacuation plan is in place that has been approved by the New Zealand Fire Service in October 2003. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring in September 2021.  A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There is a call bell system in place and there are call bells in the residents’ rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.  Partial provisional:  The existing call bell system will remain in place, and each unit will have staff allocated to each area to ensure call bells continue to be answered promptly. There is currently at least one member of staff on duty with a current first aid certificate, which will continue with the changes in level of care. There are no changes required to the fire evacuation scheme as there are no building alterations. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open, allowing plenty of natural sunlight. There are appropriate outside lights.  Partial provisional:  There are no proposed changes as resident rooms and communal areas remain the same. Lighting is adequate to promote a dementia friendly environment. |
| Standard 3.1: Infection control management  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. | FA | Dementia Care New Zealand have an organisational infection control (IC) programme that is being implemented in Tasman Rest Home and Dementia Care. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The clinical manager is the designated infection control nurse and has been in the role for one month, she has support from the registered nurses and national clinical manager. The IC team meets monthly to review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.  Visitors are reminded not to visit if they are feeling unwell. This audit was conducted under level 2 Covid-19 restrictions. All visitors and contractors are required to sign in and complete a wellness declaration and use the scan app for track and trace purposes. Temperatures are recorded and screened. Hand sanitisers are placed appropriately around the facility. Adequate supplies of personal protective equipment were sighted during the audit.  Partial Provisional:  The clinical manager is the designated infection control coordinator and has had input and oversight to the proposed PG unit to ensure infection control practices can be maintained when caring for PG residents. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at Tasman Rest Home. The infection control nurse has not yet had the opportunity to attend external infection control education but describes utilising the infection control specialist at the DHB and has support through the education coordinator and websites. The infection control team is representative of the facility.  External resources and support are available when required. Infection prevention and control is part of staff orientation. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. The DHB conducted a Covid preparedness audit, staff continue to complete wellness declarations and temperature checks on arrival to the facility for their shift. The service has purchased infrared thermometers which are available in both buildings, education sessions have been held around donning and doffing personal protective equipment. Hoist slings are cleaned between use. |
| Standard 3.3: Policies and procedures  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. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. Policies and procedures have been updated to include Covid-19. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the ongoing education of staff and residents. All infection control training has been documented and a record of attendance has been maintained. Education around infection prevention and control has been provided throughout the year and includes (but not limited to), standard precautions, hand washing, waste management. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. Electronic infection logs are maintained, which provides a report each month. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. 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 quality, and infection control meetings (link 1.2.3.6).  The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | 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 arms 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.  Partial provisional:  Restraint, dementia delirium and depression, de-escalation and disengagement education sessions are included in the annual education planner, which will continue after the transition from hospital to PG level of care, however, not all staff who will be working in the proposed PG unit have completed these sessions (link 1.2.7.5). |
| Standard 2.2.1: Restraint approval and processes  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. | FA | Responsibilities and accountabilities for restraint are outlined in the restraint policy and include roles and responsibilities for the restraint coordinator (RN) and approval group. An organisational restraint approval group meets six-monthly. The group includes the restraint coordinator, clinical manager, operations manager, DT, education coordinator, and a family representative. The Physio and GP are invited to attend. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments are undertaken by the restraint coordinator/RN in partnership with the resident and their family. Restraint assessments are based on information in the care plan, family, staff, and GP consultation and during observations. There is provision for emergency restraint if required, for safety of the residents, other residents/staff. Ongoing consultation with the family and staff is evident through multidisciplinary meetings and facility meetings. Two restraint files (one H belt and one arm restraints) reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is a RN and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur monthly in the RNs meeting and six-monthly as part of the multi-disciplinary review for the resident on restraint. Families are included as part of this review. A review of files of residents using restraints identified that evaluations were up to date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | At the monthly facility quality meetings, RN meetings, staff meetings and three-monthly restraint meetings, restraints are discussed and reviewed. Meeting minutes include a review of the restraint and challenging behaviour education and training programme for staff. Staff receive orientation in restraint use on employment. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Low | There are policies in place around staffing of the facility, however, there was no documented proposed roster for the proposed PG unit. | There is no planned roster documented for the proposed reconfigured service. | Ensure a draft roster is developed and implemented to ensure safe staffing in the reconfigured service.  Prior to occupancy days |
| Criterion 1.4.2.6  Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | There is a secure entrance to the current PG building. There is a secure door between Aio (PG unit) and Ora (hospital/rest home unit) currently. The service has indicated that they will combine the units as one PG unit. There is no transition plan documented to determine risks and plans for this to occur.  There is safe access to outdoor PG areas. There are well-placed benches and sheltered rest areas. There is a continuous looped path for Aio wing with a fence across the pathway between Ora and Aio wing creating separation between the current two wings. The director reported the fence will be moved to provide access to a larger outdoor area for residents in both areas to enjoy. There is safe level underfoot access from Aio and Ora wing to an internal courtyard and outdoor spaces. There is a ramp access to the main entry door.  Ora wing has access to an outdoor space and patio including shade. The fence surrounding Aio and Ora wing is raised and extends to the carpark at Ora wing, with vegetation in front of the fence. There is free access to the Ora wings lounge from the carpark. | The outdoor area off Ora unit is not yet enclosed and secure. | Ensure that the outdoor garden areas off Ora unit are secure  Prior to occupancy days |

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

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

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

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

|  |
| --- |
| No data to display |

End of the report.