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

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	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: 27 November 2018 End date: 28 November 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 44

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Tasman Rest Home & Dementia Care provides care for up to 53 residents. The service is divided into four smaller home-like care units, one hospital/rest home unit, one psychogeriatric care unit and two dementia care units. Occupancy on the days of audit was 44 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, General Practitioner, 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 three years. The clinical manager has been employed by the organisation as an RN for eight years and in her current role for 6 months. The resident and families interviewed about the service all spoke positively about the care and support provided.

The audit identified that one improvement is required relating to registered nurse coverage for four hours on the afternoon in the PG unit.

The service is commended for achieving a continuous improvement around the reduction of infection rates.

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.

Tasman Rest Home & Dementia Care provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as: privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code of Health and Disability Services Consumer Rights (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 managed in line with the Code. The resident and families interviewed verified ongoing involvement with community.

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.

Services are planned, coordinated and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded into practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive appropriate services from suitably qualified staff. 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. A professional development process is in situ for regulated staff. Registered nursing cover is provided 24 hours a day, seven days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.

An information booklet is available for residents/families at entry which includes information on the service philosophy, services provided and practices particular to the secure units. The operations manager takes primary responsibility for managing entry to the service in collaboration with the clinical manager. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations. Care plans reviewed were based on the interRAI outcomes and other assessments. They were clearly written, and caregivers reported they are easy to follow. Residents 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. 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. Medicines are stored and managed appropriately, in line with legislation and guidelines. There are regular visits and support provided by the community mental health team and psychogeriatrician. Food services are provided from the main kitchen and delivered in hot boxes to the unit kitchenettes. 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.

The building has a current building warrant of fitness. There is a planned maintenance schedule. There is adequate space in the facility for storage of mobility equipment. Resident's rooms, lounge areas and 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. All equipment is well maintained. All chemicals are stored safely. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff regularly receive training in emergency procedures.

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.

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

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 programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The quality team support the infection control coordinator. Infection control training has been provided within the last year. The infection control manual outlines a range of policies, standards and guidelines, training and education of staff and scope of the programme. 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	48	0	0	1	0	0
Criteria	1	99	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Tasman Rest Home & Dementia Care has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Sixteen care staff interviewed, including five registered nurses (RN), seven caregivers (three dementia, two psychogeriatric and two hospital), two diversional therapists and two activities coordinators were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities, as confirmed on interview with two rest home residents and seven relatives (five dementia care, one psychogeriatric care and one hospital level).
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 policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. There is documented evidence of discussion with the 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 (three dementia and two psychogeriatric), had copies of the EPOA on file. Copies of the resident's advance directive where applicable, is on file. Care plans and 24-hour multidisciplinary 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/or families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is regularly discussed at resident/relatives' meetings (minutes sighted). The service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the resident's family and chosen social networks.
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	Interview with relatives confirmed that visiting can occur at any time and families are encouraged to be involved with the service and care. Residents are supported to maintain former activities and interests in the community if appropriate.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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 two rest home residents and relatives confirmed an understanding of the complaints process. There is an up-to-date online complaint register. There have been 13 complaints (ten in 2018 year to date, and three in 2017) received since the last audit in March 2017. All complaints reviewed had noted investigation, timeframes and corrective actions, including letters of acknowledgement.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability (HDC) Commission. Relatives are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement. Family members interviewed, confirmed they received all the relevant information during admission.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	FA	There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		entering resident rooms. The resident and families interviewed confirmed staff respect their privacy, and support residents in making choice where able. Staff have completed education around privacy, dignity and abuse and neglect.
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	Dementia Care NZ Ltd has a Māori health plan and a cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e) of the age related residential care contact (ARRC). There were no residents who identify as Māori at the time of the audit. Linkages with Māori community groups are available and accessed as required. The service has a culture advisor who is available to provide assistance and guidance for any Māori residents.
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 and any beliefs or values are discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the resident's needs are being met. Discussion with residents and family members confirmed values and beliefs are considered.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the seven staff files sampled. Staff comply with confidentiality and the code of conduct. The RNs and allied health professionals practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the operations managers, the clinical manager, RNs and care staff confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Policies and procedures meet the health and disability safety sector standards. Staff stated they are made aware of new/reviewed policies and sign to say they have read them. An environment of open discussion is promoted. Staff reported that the operations manager and clinical manager are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. A quality monitoring programme is

		implemented, and it monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives' meetings, quality meetings, infection control meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management. Family members interviewed spoke very positively about the care provided and were well informed and supported. There are clear ethical and professional standards and boundaries within job descriptions.
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 and for residents who do not have any family to notify. The managers and RNs confirmed family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Families receive newsletters that keep them informed on facility matters and events. Fifteen incident and accident forms reviewed for October and November 2018, evidenced that family are notified following adverse events or when there is a change in residents' condition. Resident/family meetings encourage open discussion around the services provided (meeting minutes sighted). There is access to an interpreter service as required.
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 smaller home-like care units, with one 15-bed dual-purpose hospital/rest home unit (Ora home), one 12-bed psychogeriatric care unit (Aio home) and two separate dementia care units with 13 beds in the Ata Hapara unit and 13 beds in the Rangi unit. The service is in two separate buildings with a walkway between them. The hospital/rest home and psychogeriatric care units are in one building and the dementia care units are in the other. At the time of the audit there were 44 residents in total. There were nine hospital residents, two rest home residents, twenty-one residents across the two dementia care units and twelve residents in the psychogeriatric care unit. All residents were either under the ARRC or the ARHSS contract. Dementia Care NZ has a corporate structure in place which includes two directors and a governance team of managers and coordinators. The operations management leader and national clinical manager support the operations manager and the clinical manager respectively. The vision and values of the organisation underpin the philosophy of the service. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. There is a strategic plan for 2018-2021 and a business plan for 2018-2019 in place for all DCNZ facilities. The 2017 organisational goals have been reviewed by the governance team, company clinical director, quality systems manager and company educator/psychiatric RN. An operations manager and a clinical manager oversee Tasman Rest Home & Dementia Care on a

		daily basis. The operations manager reports directly to the operations management leader and the clinical manager reports directly to the national clinical manager who reports to the clinical director. The operations manager has been in the role for three years. The clinical manager is responsible for the clinical oversight of the service and has been in the position for six months.. An organisational operations management leader, national clinical manager, quality systems manager, company clinical director, company educator/psychiatric RN and directors provide support to the team at Tasman Rest Home & Dementia Care. During the audit the company director, company clinical director, company educator/psychiatric RN and national clinical manager were present. The operations manager and the clinical manager have each attended at least eight hours of education in the past 12 months in relation to their respective roles. The organisation holds an annual training day for all operations managers and all clinical managers.
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	During the temporary absence of the operations manager, the clinical manager covers the operations manager's role. During the temporary absence of the clinical manager a senior RN covers under the supervision of the clinical manager from a sister company of DCNZ located in Blenheim.
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. Progress with the quality and risk management plan is monitored through the quality meeting. The operations manager and clinical manager log and monitor all quality data. Meeting minutes are maintained, and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Quality improvement (QI) reports are provided at the monthly quality meeting. Staff interviewed confirmed involvement and feedback around the quality management system. Data is collected on complaints, accidents, incidents, infection control and restraint use. Benchmarking with other DCNZ facilities occurs on data collected. The service has policies and procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The internal audit schedule for 2018 is being completed. Areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. 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. The organisation's annual resident/relative satisfaction survey was completed in January 2018. Overall results report that residents and relatives are satisfied with the service. Falls prevention strategies are in place that includes assessment of risk, medication review, assessments with physiotherapy input and exercises/physical activities. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.
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	There is an accidents and incidents reporting policy. An online incident/accident register is maintained. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality improvement and clinical meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Fifteen incident forms reviewed demonstrated that all appropriate clinical follow-up and investigation had occurred following incidents. Neurological observations were completed for seven resident falls reviewed for unwitnessed falls or with potential head injury. Discussions with the operations manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications and were able to provide examples. There have been no section 31 notifications required to be made since the last audit.
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 management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Current practising certificates were sighted. Seven staff files were reviewed (one operations manager, one clinical manager, one RN, three 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 described the orientation programme. The service uses the "Best Friends" approach to caring for residents and staff complete an in-service education programme on this approach to care. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. Eight hours of staff development or in-service education has been provided annually. The clinical manager and RNs are able to attend external training, including sessions provided by the local DHB. All RNs have completed first aid training. The organisation has an education coordinator who is a registered psychiatric nurse. The clinical director leads the professional development project across the organisation. Four of five RNs have achieved and maintained interRAI competency. There

		are 30 caregivers who work in the dementia and psychogeriatric units. Twenty-seven caregivers have completed the required dementia unit education modules. Three caregivers are in the process of completing national dementia unit modules and have been employed for less than 18 months.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Moderate	A policy is in place for determining staffing levels and skills mix for safe service delivery. Staffing rosters for each care unit were sighted and there are sufficient care staff on duty to meet the resident needs and resident safety on different shifts. There is a full-time plus on-call operations manager and clinical manager. Each care unit has a home manager (senior caregiver) on morning shift Monday to Sunday in addition to the care staff on the roster. Interviews with staff, residents and family members confirmed there are sufficient staff to meet the needs of residents. The service has an RN on duty based in the PG unit who covers 26 residents the hospital and PG units from 4.30 pm-8.30 am. These homes are adjacent to each other in the same building. The service has a 12-bed psychogeriatric unit (Aio), an 11-bed hospital unit (Ora), an 11-bed dementia unit (Ata Hapara) and a 10-bed dementia unit (Rangi). The clinical manager works full-time Monday to Friday and is available on-call 24/7. Additionally, there is a RN on duty on each shift seven days per week in both the hospital unit and psychogeriatric unit except for the afternoon and night shift. During the day the RN in the hospital unit oversees the dementia units. There is a home manager (senior caregiver) on duty in each of the dementia units on morning and afternoon shifts. They are supported by a caregiver on these shifts. On night duty, there is one caregiver on duty in each dementia unit. In the hospital and psychogeriatric units two caregivers support the RNs on the morning and afternoon shifts. There is an RN based in the 12-bed psychogeriatric unit 24/7 which is attached to the 15 dual-purpose rest home/hospital unit. Additionally, there is another RN based in the hospital/rest home from 8.30 am until 4.30 pm. Staff are visible and available to meet resident's needs, as reported by the two residents and family members interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and	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 individual record. Residents' files are protected from unauthorised access by being held securely in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrated service integration with only medication charts held on the electronic medication

accessible when required.		management programme.
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 resident 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 (one rest home, one hospital, three dementia and two psychogeriatric level of care) 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 accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication round sighted. The medication fridge temperatures are checked daily. Eye drops are dated once opened. Medication reconciliation of monthly robotic packs is completed by either two RNs or an RN and senior medication competent carer and any errors fed back to the pharmacy. RNs only administer medications in the dual-purpose rest home/hospital unit and psychogeriatric unit. Senior care staff administer medications for rest home dementia level care residents. All staff that administer medicines are competent and have received medication management training. Fourteen electronic medication charts were reviewed (two rest home, two hospital, six dementia and four psychogeriatric). Medical practitioners document medication charts correctly and there was evidence of three monthly reviews by the GP. There is a monthly review of antipsychotic medication use. There was one resident self-administering nebulisers and inhalers on the day of audit. The resident's competency had been reviewed by an RN and GP three monthly and medications were securely stored in the resident's room. Standing orders were not in use.

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	There is a registered food control plan. All meals at Tasman Rest Home and Dementia Care are cooked on site by qualified cooks. The kitchen service manual covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. There is a registered food control plan. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. All foodstuffs are appropriately stored and labelled and/or dated. All kitchen staff have attended food safety and hygiene, chemical safety and relevant in-service training. Containers of food are transported in hot boxes to each area which all have kitchenettes, where caregivers plate and serve the meals. The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Pureed and normal diets are provided. Resident likes, and dislikes are known, and alternative foods are offered. Cultural and spiritual needs are met. There were adequate fluids sighted in the kitchenette fridges and supplement protein drinks are available. There are additional nutritious snacks available over 24 hours for the dementia and psychogeriatric unit residents. Residents and the family members interviewed were very happy with the quality and variety of food served.
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	The information gathered at admission is used to develop care needs and supports to provide best care for the residents. Risk assessment tools are reviewed at least three monthly. InterRAI assessments have been completed for all residents and reviewed at least six monthly. The outcomes of interRAI assessments, including the risk assessments, were reflected in the long-term care plans reviewed. The diversional therapists and other activities staff complete a social assessment and activity care plan in consultation with the resident/family.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans reviewed, evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident-centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the physiotherapist, podiatrist, wound care specialist and mental health care team for older people. The management of behaviours that challenge was documented in the files reviewed including triggers to behaviour and interventions to manage outbursts. The two psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. The care staff interviewed, advised that the care plans were easy to follow and assisted them when caring for the 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. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents' needs changed. The two resident files sampled from the psychogeriatric unit all included management of nutrition and monitoring for weight loss. Resident falls are reported on incident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls, or falls where residents hit their heads. Care staff interviewed stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. Photos of wound progress are taken. There are currently six wounds being managed. There has been input from the GP and wound care nurse specialist for one chronic ulcer. There are currently three pressure injuries (two stage two and one stage one) being managed, and wound care plans were in place. There has been input from the GP and wound care nurse specialist. 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 weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. There is liaison with the mental health for older person's team. There is specialist input into the resident's care in the psychogeriatric unit. The community mental health/psychiatric nurse visits at least two weekly and liaises closely with the clinical manager, RN, GP and the psychogeriatrician based at Nelson. The community mental health/psychiatric nurse (interviewed) confirmed the psychogeriatrician is readily accessible. The psychogeriatrician visits four to six weekly. There is evidence in the medical notes of

		GP communication with the psychogeriatrician in regard to medication review. The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment.
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	A team of four activities staff including two diversional therapists (DT) and two DTs in training, provide an activities programme for part of each day in each area. The DTs meet monthly to review the activities for each area for the month ahead, and to identify times when sessions can be shared across units. Each unit has a separate programme. Each of the four areas have afternoon activities from 1.00 pm to 5.30 pm seven days a week. Care staff on duty are involved in individual activities with the residents as observed on the day of audit. There are resources available for staff for activities. There is a weekly programme in large print on noticeboards in all unit 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. This is particularly noticeable in the psychogeriatric units where residents' concentration spans are often short. Activities include exercises, games, quizzes, music, sensory dough play and walks outside. 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. The rest home and hospital programme is flexible to meet the needs of the residents and include (but are not limited to); exercise, movements to music, word games, musical bingo, old time stories, newspaper reading, crafts, baking, happy hours, outdoor walks and pampering activities. The dementia programme is focused on household/meaningful tasks, reminiscing and sensory activities such as manicures and pampering activities, baking, garden walks, chats, music and sing-alongs, board games, café style afternoon teas, bowls and happy hours. Regular entertainment is scheduled. The programme for the psychogeriatric residents is focused on individual and small group activities that are meaningful but not limited to: walks in the garden, picking flowers, colouring in, polishing cutlery, folding napkins, music, board games, aromatherapy and reading poetry. There is community input from clubs, retail groups such as Bunnings, pre-schools and schools. The service works closely with age concern and Alzheimer's NZ and is involved with outings for a cuppa events held locally. Inter-rest home activities and animal visits are enjoyed. There are weekly interdenominational church services and Sunday Catholic services/communion. Entertainment is regularly scheduled in each unit. Ethnic and cultural preferences are met as evidenced in the activity care plans sampled. There are van outings. The activities staff have a current first aid certificate. Residents have an activity assessment 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 activity plan is based on this assessment. Activity plans are evaluated at least six-monthly. Resident and family meetings are

		held. Resident files reviewed identified that the individual activity plan and 24-hour multidisciplinary care plan is reviewed with the care plan review. Caregivers were observed at various times throughout the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions and dementia. Activities were observed to be occurring in the lounges during the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Files reviewed demonstrated that the long-term care plans reviewed had been evaluated by the RNs six monthly or when changes to care occurs. Reassessments have been completed using interRAI LTCF for all 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. Activities plans are in place for each of the residents, and these are also evaluated six monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. 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 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.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There are four units, Ora, Aio, Ata Hapara and Rangi that provide rest home, dementia, psychogeriatric and hospital level 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 2019. 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. The hot water temperatures checked weekly, were recorded at 45 degrees Celsius or below in all resident areas. Medical equipment has been checked and calibrated and testing and tagging of electrical equipment has been conducted. An environmental safety audit is completed six monthly. The service has a smoking policy and smoking is only permitted in designated outside areas. 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, 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.
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.
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.

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.
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. 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 residents interviewed were satisfied with the cleanliness of the communal areas and their bedrooms.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service in October 2003. There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies are included. Six-monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 20 August 2018. 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. There are civil defence supplies and first aid kits available. Emergency equipment is available at the facility. Short-term backup power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. The clinical manager holds a current first aid certificate. 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.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe	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.

ventilation, and an environment that is maintained at a safe and comfortable temperature.		
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	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. Meetings are monthly, and minutes are available for staff. Education is provided for all new staff on orientation. The infection programme is reviewed annually at an organisational level and is linked into the objectives of the quality and risk management plan. The IC programme plan, and IC programme description are available. There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the infection control committee at service and organisational level. The facility has access to professional advice within the organisation, from GPs, the CM (who attends advanced training in infection control bi-annually) and the infection control team at the DHB. Hand hygiene notices are in use around the facility. There is a staff health policy and staff infection and work restriction guidelines.
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	The designated infection control (IC) coordinator is an RN. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising the CM, RNs and senior care staff representatives from each unit) has good external support from the local laboratory infection control team. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. The infection control committee is made up of a cross-section of staff from across the service. The IC nurse has support from the company educator/psychiatric RN, and she has completed external training.
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.	FA	There is an infection control manual which includes policies and procedures appropriate for the size and complexity of the service. There are policies and procedures that include (but are not limited to); (i) infection control nurse responsibilities, (ii) antimicrobial usage, (iii) infection control including renovations and construction, (iv) accidental exposure to blood, (v) health care waste, (vi) definitions of infections, and (vii) outbreak management. Any changes or updates to the infection control policies are notified at the staff and quality meetings and are recorded in the staff bulletin.

These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand competencies including hygiene competency. The IC coordinator (RN) has completed external training. Staff receive annual infection prevention and control education.
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.	CI	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 quality, infection control and staff meetings. 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. The service has exceeded the required standard around an implemented plan that has reduced urinary tract infections.
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 dementia units (two T belts and two 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. Staff regularly receive education and training on

		restraint minimisation and managing challenging behaviours.
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. A restraint approval group meets six-monthly. The group includes the restraint coordinator, clinical manager, operations manager, DT, company educator and a family representative.
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. Three restraint files (one T belt and two 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 three files of residents using restraints identified that evaluations were up-to-date.
Standard 2.2.5: 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

Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of 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 Moderate	There is an RN based in the 12-bed psychogeriatric unit 24/7 which is attached to the 15 dual-purpose rest home/hospital unit. Additionally there is another RN based in the hospital/rest home from 8.30 am until 4.30 pm. The psychogeriatric unit and rest home/hospital are in the same building in very close proximity.	There is one RN rostered over 24 hours a day and located in the psychogeriatric unit wing. The contract with the local DHB states that the psychogeriatric unit and hospital unit can share a RN between 10.00 pm - 7.00 am only if the service is under 50 residents. However, there is not always a RN rostered in the hospital as well as the psychogeriatric unit between 4.30 pm and 10 pm.	Ensure RN covers meet the requirements of the ARC and ARHSS contracts. 60 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 3.5.7 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.	CI	All urinary tract infections are documented on individual infection summary sheets. All UTIs are reviewed holistically at an individual level and involve input from care staff, the resident, RNs and the CM.	The service implemented the following strategies around reducing the incidents of urinary tract infections (UTIs) that included: (i) education on the importance of hydration, (ii) education session presented by a microbiologist at clinical managers’ study day on the prevention and management of UTIs, (iii) introduction of extra fluid rounds in warmer weather and (iv) establishing a toileting regime that meets individual resident’s needs. As a result of the strategies implemented, the facility has remained below the organisational target range of 1.51 UTIs per 1000 bed nights at 1.00 in hospital level care, 0.01 psychogeriatric level of care and 1.36 dementia level care over a twelve-month period. In 2015, Tasman Rest Home & Dementia Care identified urinary tract infections rates at 1.51 and 1.36 respectively were higher than other similar facilities. A local infection control objective was identified in January 2016 with a goal of reducing the incidence by 10% across all levels of care. This goal has continued over 2017 and 2018. An action plan documented a number of initiatives to assist in meeting the goal. The clinical manager attended advanced education on infection control practise and all staff have received regular training specific to urinary tract infection prevention. All residents with UTIs have a thorough physical assessment and staff are provided with oversight and supervision during hygiene and toileting cares. The use of yoghurt has been introduced for residents who regularly have UTIs. All individuals with UTIs are reviewed by the

			CM and infection control resource nurse to identify causative factors and ensure all interventions are in place. Early warning signs are acted on promptly and RN involvement in direct care has increased. Review of infection control rates in January 2017 for the year 2016, indicated a reduction in UTI rate of 93%. As a result of the above initiatives the average annual UTI rate has consistently remained below 0.30 per bed night since 2016.

End of the report.