

Tainui Home Trust Board - Tainui Resthome

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Tainui Home Trust Board
Premises audited:	Tainui Resthome
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 3 March 2021 End date: 4 March 2021
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:	56

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Tainui Rest home provides residential services at rest home and hospital level care for up to 60 residents. The facility is operated by Tainui Home Trust Board and is managed by a chief executive officer.

Residents and families reported satisfaction with the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, managers, staff, a general practitioner, a nurse practitioner and the chairman of the trust board.

Areas requiring improvement relate to clinical governance, orientation documentation, ongoing staff training, staffing levels, aspects of care planning and responsibilities relating to infection prevention and control.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Tainui Home Trust Board -Tainui Rest home. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services at Tainui Rest home are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

Tainui Rest home has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively. Two complaint investigations have been investigated by external agencies since the previous audit.

Organisational management

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

The service is managed by a chief executive officer who is new to the position. The chief executive officer is supported by the trust board, the operations manager, the relieving clinical nurse manager and the quality assurance coordinator.

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

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

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

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using an integrated electronic and hard copy files.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Tainui Rest Home liaises with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. All residents' files reviewed demonstrated that needs, goals, and outcomes are identified and reviewed on a regular basis. Residents and their family members reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is run by a diversional therapist and a recreation co-ordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community. Two facility vans are available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses, enrolled nurses, or senior care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

There is a mix of rooms with shared full ensuites and those with a toilet and wash hand basin with a shared shower. Adequate numbers of additional bathrooms and toilets are available. There are several lounges, dining areas and alcoves. External areas for sitting and shading are provided.

An appropriate call bell system is available, and residents reported timely responses to call bells. Security and emergency systems are in place. Residents reported timely responses to call bells. Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly.

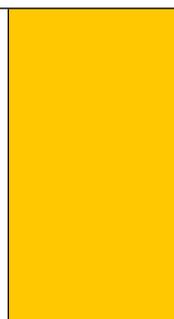
Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is undertaken on site and the cleaning and laundry are evaluated for effectiveness.

Restraint minimisation and safe practice

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

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The infection prevention and control programme aim to prevent and manage infections. Specialist infection prevention and control advice is accessed from the Taranaki District Health Board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and procedures.

Surveillance of aged care specific infections is undertaken, and data is trended and benchmarked. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	5	0	0
Criteria	0	95	0	1	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Tainui Home Trust Board -Tainui Rest home (Tainui) has procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training (which occurred on 27 & 28 January 2021), as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, and collection of health information.</p> <p>Advance care planning, establishing, and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p>

		Staff were observed to gain consent for day-to-day care on an ongoing basis.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility. Family members and residents spoken with, were aware of the Advocacy Service, how to access this, and their right to have support persons.</p> <p>Staff were aware of how to access the Advocacy Service.</p> <p>Three spiritual advisors are onsite at Tainui daily, and are available to assist residents if required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and complaints information and forms are available at the main entrance.</p> <p>Eight complaints have been received since the last audit and these have been entered into the complaints register. Complaint documentation was reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible.</p> <p>The quality assurance coordinator (QAC) is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required.</p> <p>The QAC reported there have been two complaint investigations by the Health and Disability Commissioner (HDC) and the local DHB since the previous audit. One complaint was to the DHB concerning the care of a resident. Documentation was requested from Tainui and this was supplied to the DHB. A letter dated 12 January 202 from the DHB stated the complaint was not substantiated and is formally closed. The complainant then complained to the HDC and</p>

		<p>documentation reviewed evidenced the HDC has requested further information. The clinical notes have been provided to the HDC with further information to follow.</p> <p>The other complaint was to the DHB in September 2019 about the care of a resident. Recommendations from the DHB following the investigation have been completed by Tainui and documentation from the DHB evidenced corrective actions have been completed and the complaint is formally closed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members of residents, when interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas around the facility together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and family members of residents confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families, the General Practitioner (GP) and the Nurse Practitioner (NP). There are two double rooms in the facility, which are only used for couples or occupy one resident only. All single residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan. Three spiritual advisors are accessible to residents of Tainui daily.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff and is planned to be provided on an annual basis. This however has not occurred in 2020 (refer criterion 1.2.7.5).</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There were no residents in Tainui at the time of audit who identified as Māori. Interviews verified that staff could support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisors.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and their family members verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A NP and GP expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a code of conduct as part of their individual employment contract. Ongoing education has been provided on an erratic basis, with attendance being poor as confirmed in staff training records (refer criterion 1.2.7.5). Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, district nurses, community dieticians, services for older people, and mental health services for older persons. The GP and NP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p>

		<p>Staff reported they receive management support to access external education through the Taranaki District Health Board (TDHB), the local hospice, an external training establishment and online learning hubs.</p> <p>Other examples of good practice observed during the audit included the recent introduction of an electronic quality management system which includes a New Zealand national aged care online benchmarking programme, to enable ongoing improvement in the care provided by Tainui. This system has identified a high number of falls between the hours of 7-8pm at night and a need for increased staffing during these hours (refer criterion 1.2.8.1). The system enables the GP and NP to access residents' care and medication records at any time. Interview with the NP identified this being particularly valuable when managing a resident's pain as it enables access to residents' progress notes and any pro re nata (PRN) medications being required, and the possible need for increases in regular dosages.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members of residents stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via TDHB, Language Line, the Blind Foundation, and the Deaf Foundation when required. Staff knew how to access these services though reported interpreter services were rarely required due to all present residents being able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	PA Moderate	<p>Tainui Rest Home is governed by a trust board of nine members who are responsible for setting the strategic direction and the service at the facility. The business plan 2020-2022 has a mission statement, business objectives and values, strengths, weaknesses, opportunities and threats. The Tainui strategic document 2020-2021 includes a vision and four core enabling strategies – people first; excellent care; develop services and not for profit/financially and core indicators. The board meeting minutes evidenced identified objectives, with actions and progress on actions. The CEO and senior managers present reports to the board at their board meetings. Review of reports confirmed this.</p> <p>The facility is managed by a CEO who is new to the position and started employment two days prior to the audit. The chairman of the trust board has been acting as the interim CEO since October 2020 when the last CEO left. The CEO is new to the aged care sector, is a qualified</p>

		<p>charted accountant and has an extensive background in management and financial services, both in NZ and offshore. The CEO is supported by the trust board, the relieving clinical nurse manager (relieving CNM) and other senior staff.</p> <p>Due to personal reasons, the clinical coordinator resigned from their position in January 2020 and has gone back to being an RN on the floor. The position is yet to be filled.</p> <p>A relieving CNM has been employed on a fixed term contract of six weeks while the current CNM is on planned leave, the length of which is not known. The relieving CNM has been in the position for two weeks at the time of audit. The relieving CNM is an experienced clinical nurse manager.</p> <p>The last CNM left employment in January 2020. There was no CNM until April 2020 when the current CNM was recruited from within the workforce. The position was not advertised. The current CNM does not have experience for the role of CNM. Prior to this position the CNM was an RN on the floor working part-time for three shifts a week. The CNM has not completed an orientation to the position. Interviews of all levels of staff evidenced there has been a lack of clinical leadership. Care staff reported they felt unsettled and that the experienced RNs and ENs ensured the care of residents remained safe.</p> <p>Tainui Rest Home is certified to provide hospital level and rest home level care. Apart from two small rooms, all bedrooms have been approved as dual-purpose beds, rest home and hospital level residents are mainly cared for in two designated areas.</p> <p>The service provider has contracts with the DHB for aged related residential care services (ARRC), respite, long term chronic health conditions (LTCHC) and enhanced intermediate care (EICAT). On the day of audit there were 13 hospital level residents and 39 rest home level residents under the ARRC contract. There are also four beds funded by the DHB for residents under the enhanced intermediate care (EICAT).</p> <p>Residents from Tainui village have occupational rights agreements (ORAs) and can access respite care in the facility if required.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>If the CEO is absent, the operations manager will cover all aspects of the service with support from the trust board and quality assurance coordinator. During absence of the RCNM, the senior registered nurse is available to cover for the clinical service.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality and risk management system is well embedded at Tainui. Quality data is managed well by the quality assurance coordinator who enters it into an electronic programme provided by an external company. Quality data is collated and analysed for any trends. Corrective actions are developed and implemented and reported to staff. Graphs are generated and include benchmarking. Various staff meetings have been held regularly. Minutes reviewed confirmed this.</p> <p>The resident satisfaction survey for 2020 has been collated and evidenced a high satisfaction rate.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are reviewed and updated by the external company who provides them, and were current. Obsolete policies are archived in the electronic system. Staff are notified via memos of reviewed and updated/new policies. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery.</p> <p>A risk management plan included a risk assessment matrix. The hazard/risk register includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risks. All hazards are entered onto an adverse event form. The hazard/risk register includes actual and potential hazards and the actions put in place to minimise or eliminate the hazard. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Adverse, unplanned or untoward events are documented by staff on adverse event forms and the RNs review the forms and are responsible for any corrective actions. The quality assurance coordinator (QAC) enters the data into the electronic programme. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Policies and procedures comply with essential notification reporting. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The QAC reported there have been no Section 31 notifications to HealthCERT since the previous audit.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>Policies and procedures relating to human resources management are in place. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, competency assessments, education records and police vetting. Not all staff files evidenced a completed orientation, including the CNM (Refer to criterion (1.2.1.3)).</p> <p>An orientation workbook is generic and role specific and includes competencies. The workbook is completed within three months of employment. Staff performance is reviewed at the end of this period. Orientation for staff covers all essential components of the service provided.</p> <p>An in-service education programme is in place and covers all required subjects. 'Toolbox talks' at handover, specific topics relating to resident's health status and one to one training is provided, however, this are not recorded. The programme has not been followed due to Covid 19 and because there were months when there was no CNM to coordinate and implement the programme. The local DHB also provides education sessions for RNs. Individual records of education are held on staff files and electronically. Attendance at training sessions is generally poor apart from a session on 'bullying'. Competencies were current, including for medication management, with the exception of restraint competencies, which were not current. Attendance records are maintained. Of the nine RNs, two are interRAI trained as well as the RCNM. All RNs, ENs and other staff have current first aid certificates.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. Five care staff have attained level 2, 12 have level 3 and six have level 4.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff interviewed confirmed they have completed an orientation, including competency assessments and their performance appraisals are current. Staff interviewed confirmed on-going in-service training has been spasmodic.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service. The RCNM reported the rosters are reviewed continuously and dependency levels of residents and the physical environments are considered as the two areas are separated.</p> <p>In the hospital area, at the time of audit, there were 19 residents and in the rest home area 33 residents, three of whom require two staff to hoist. Quality data around resident falls evidenced a spike between 7pm and 8pm at night in the rest home area. Interviews of senior staff, caregivers, RNs and ENs evidenced staff are struggling to safely care for residents as the acuity levels have</p>

		<p>increased. The relieving CNM is aware of this and is currently reviewing the roster. The relieving CNM stated they now have a casual pool of care givers to call on if required.</p> <p>The relieving CNM is fulltime Monday to Friday, eight hours a day. There are either two RNs on the morning shift or one RN and one EN. Six caregivers are on the morning shift, three in each area. An RN and EN are on the afternoon shift, with four caregivers on duty. An RN and EN are on the night shift with two caregivers. The relieving CNM is on call for clinical matters and the CEO for non-clinical matters.</p> <p>Apart from two RNs, the rest are experienced RNs and ENs (four) who have worked in the sector for many years. Laundry and cleaning is undertaken by dedicated staff. A diversional therapist and recreation person are employed and provide activities Monday to Friday.</p> <p>Apart from the afternoon shift, care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families reported they are happy with the staffing levels and there are enough staff on duty to provide them or their relative with a high standard of care.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents enter Tainui when they have been assessed by the local Needs Assessment and Service Coordination (NASC) Service, as requiring the level of care provided by Tainui. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the relieving clinical nurse manager (CNM). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained</p>

		completed demographic detail, assessments, and signed admission agreements in accordance with contractual requirements.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the TDHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's electronic signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at Tainui at the time of audit.</p>

		<p>Medication errors are reported to the RN and CNM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in June 2020. Recommendations made at that time have been implemented. The menu is diverse and offers residents a range of choices at each meal.</p> <p>An up-to-date food control plan is in place at Tainui and was audited by the New Plymouth District Council on 16 October 2020. One corrective action requiring the recording of use by dates on sauces when they have been decanted from the original bottle has since been addressed. The food control plan has been verified for eighteen months and is due to expire on 16 June 2022.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation,</p>	FA	<p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the relieving CNM. There is a clause in the access agreement related to when</p>

where appropriate.		a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission to Tainui, residents are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening, and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessments using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. In seven of the nine files reviewed interRAI assessments were completed within three weeks of admission and at least every six months unless the resident's condition changes. The two remaining residents had not had interRAI assessment completed within 21 days of admission (refer criterion 1.3.5.2) and had not had a review six months later as they had not been a resident in Tainui for six months at the time of audit. Interviews, documentation, and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>Seven of nine residents have current interRAI assessments completed by two trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Care plans reviewed evidenced service integration with progress notes, activities note, medical and allied health professional's notations clearly written, informative and relevant. Care provided to residents was observed to be timely and appropriate and well documented in progress notes. However, any change in the plan of care required by the resident was not consistently updated by the RN in the care plan. The care plan therefore did not always reflect the support the resident required, the outcome of the integrated assessment process, and other relevant clinical information. This is an area requiring improvement.</p> <p>Care needs were verbally passed on to relevant staff. Evidence was sighted that this finding related only to care plan documentation. The care provided to the residents was evidenced to be consistent with best practice guidelines. Residents and family members reported participation in the development and ongoing evaluation of care plans.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Except for that referred to in criterion 1.3.5.2, documentation, observations, and interviews verified the care provided to residents was consistent with their needs and goals. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP and NP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. Care staff confirmed that care was provided as outlined at handover and in verbal orders rather than in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a diversional therapist and a recreation coordinator.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activity programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal care plan review every six months.</p> <p>There are two planned monthly activities programme sighted at Tainui, one for hospital residents and one for rest home and village residents. The programme is diverse and matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included exercises, church services, newspaper reading, choir, 'knit and natter', baking, crafts, outings, movies, entertainment, 'happy hour', and bowls. Van outings are held twice a week.</p> <p>The activities programme is discussed at the monthly residents' meetings and minutes indicate residents' input is sought. Resident and family satisfaction surveys demonstrated satisfaction with the activities programme provided at Tainui. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes, however these are not often documented in the care plan (refer criterion 1.3.5.2). Short-term care plans were regularly reviewed for infections and wounds, and progress evaluated as clinically indicated. GPs and the NP have access to the electronic resident management system and the medication system and</p>

		make changes based on the evidence seen in progress notes and medication records. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Residents of Tainui are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP, NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN, NP, or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies and procedures specify labelling requirements in line with legislation. Documented processes for the management of waste and hazardous substances are in place. Incidents are reported in a timely manner. Safety data sheets were sighted and are accessible for staff. The hazard register was current.</p> <p>Protective clothing and equipment were sighted that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building systems status report in lieu of a building warrant of fitness is displayed at the front entrance that expires on the 15 January 2022. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Residents and families confirmed they can move freely around the facility and that the accommodation meets their or their relative's needs. Passageways are wide and there is good room for resident to pass comfortably.</p> <p>There is a proactive and reactive maintenance programme, and the buildings, plant and equipment are maintained to an adequate standard. Maintenance is undertaken by the maintenance people with oversight by the operations manager. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current. Hot water temperatures at resident outlets are</p>

		<p>maintained within the recommended range.</p> <p>There are external areas available that are appropriate to the resident groups and setting. Large external courtyards with seating and shade are available for residents to frequent. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. A mix of rooms with shared full ensembles and rooms with a toilet and wash hand basin with shared showers are available. There are additional toilets and showers near the residents' rooms. Bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. Separate bathrooms for staff and visitors are available.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All rooms are single apart from two double rooms that are currently used as single accommodation. There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. Rooms are personalised with furnishings, photographs and other personal items on display. All bedrooms are large enough for residents and staff and equipment to manoeuvre within.</p> <p>There is adequate room in the facility to store mobility aids, such as mobility scooters, wheelchairs and walkers.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Various communal areas are available for residents to frequent. The dining and lounge areas in both units have good space and enable easy access for residents and staff. Residents can access areas for privacy. The furniture in the lounges and dining rooms is appropriate to the setting and residents' needs.</p> <p>There is adequate space to accommodate wheelchairs in the dining rooms and lounges. A large room is used for activities including an exercise programme and cooking.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken on site. Cleaners and laundry staff demonstrated a sound knowledge of the cleaning and laundry processes. The cleaning of the facility is to a high standard. Chemicals are stored securely and were in appropriately labelled containers. The cleaning trolleys are stored securely when not in use. The representative from the chemical company visits twice a week. Residents and families interviewed reported personal clothes are managed effectively and returned in a timely manner. There are separate named baskets for each individual resident. Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 26 February 2015. A fire evacuation drill takes place at least four monthly with a copy sent to the New Zealand Fire Service. The last trial was held on the 21 October 2020. The orientation programme includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Policies and procedures and guidelines for all emergency planning, preparation and response are displayed and flip charts are displayed throughout the facility to guide staff. Disaster and civil defence planning guides direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency.</p> <p>Monitoring of civil defence supplies is the responsibility of the operations manager. Adequate supplies for use in the event of a civil defence emergency including food, water, blankets, torches, mobile phones and a gas barbecue were sighted and meet the requirements for the number of residents able to be accommodated at the facility. Water storage meets the requirements for the emergency water storage recommendations for the region.</p> <p>Call bells alert staff to residents requiring assistance. Call bells were observed in service areas within the facility.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the facility is checked by staff. Surveillance cameras are situated in communal areas and a notice is visible at the front entrance. Sensor lights are situated externally, and a security firm completes a rounds at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	FA	<p>Heating is provided by radiators and ceiling heating and cooling systems in the lounges. There are procedures to ensure the service is responsive to resident feedback in relation to heating and</p>

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>ventilation. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. Both the building and outside areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>PA Moderate</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff, and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level. The infection control programme and manual are reviewed annually, by the quality coordinator and the infection control advisor.</p> <p>Up until a week prior to audit, there had been no designated Infection Control Coordinator (ICC) at Tainui since January 2020, to manage the infection control programme. (refer also criterion 1.2.1.3 and 1.2.7.5).</p> <p>Infection control matters, including surveillance results, are entered into the facility's electronic database by the RN who is on duty when an infection is identified. The electronic database then creates a short-term care plan in the resident's file. Infection control matters and surveillance results are tabled at the monthly board meeting, six weekly RN/EN meeting, six weekly staff meeting and the six weekly quality meeting. The recent appointment of a relieving CNM, has included the appointment of an infection control co-ordinator.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The relieving CNM, has been appointed the ICC, and has appropriate skills, knowledge, and qualifications for the role. The ICC has undertaken online training in infection prevention and control as verified in training records sighted. Well-established local networks with the infection control team at the TDHB are available and expert advice from an external advisory company is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation, and documentation verified staff have not received ongoing training in IPC (refer criterion 1.2.7.5). When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided, at handover, in response. An example of this occurred when there was a recent increase in urinary tract infections. Evidence verifies education around the management of Covid-19 has occurred as toolbox sessions daily, however no documented record of this is sighted.</p> <p>Education with residents and family members is generally on a one-to-one basis, via newsletters, or emails and has included reminders about visitor restrictions, restrictions on outings, handwashing, advice about residents remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance of infections at Tainui is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The Quality Coordinator reviews all reported infection data. Monthly surveillance data is collated to identify any trends. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and</p>

		<p>comparisons against previous years. Data is benchmarked nationally with other aged care providers.</p> <p>There have been no Norovirus outbreaks at Tainui this year.</p> <p>A good supply of personal protective equipment is available. Tainui Rest Home has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service demonstrated the use of restraint is actively minimised. Equipment used included sensor mats and low beds. There were two residents using restraint and four residents using an enabler during the audit. The senior RN stated the aim is to have no restraint use in the facility. Policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers and knew the difference between the two.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The service has policies and procedures in place to guide staff in the management of restraints. The restraint co-ordinator demonstrated a sound knowledge relating to minimising restraint use, current and potential risks of restraint, the approval process, and monitoring and review of the restraint process.</p> <p>Restraint meetings are held and review of the minutes confirmed this. Required documentation relating to restraint and enabler use is recorded.</p> <p>The restraint approval process is being followed and current consents were in place for the use of restraint. Bedrails, lap belts and a fall out chair have been approved.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Resident care plans evidenced a detailed assessment including risks associated with restraint use.</p> <p>The restraint checklist and consents were evidenced in the residents' files reviewed. Close monitoring and review of the ongoing requirement for restraint is documented with possible alternatives and strategies which are discussed with family and staff.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint coordinator stated that restraints are used as a last resort after alternative interventions have been explored. The restraint register is current and meets the standard. Staff do not have current restraint competency assessments (Refer to criterion 1.2.7.5).</p>

		<p>Staff are aware of advocacy services and that support is available. The contact details for this service are documented and the service can be accessed when needed to inform residents and their families.</p> <p>Documentation in the residents' files relating to risk around restraint is individualised and gives good detail.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint coordinator confirmed evaluations of the restraints are completed at three-monthly intervals. Evaluation and review of restraints meet the standard. The restraint coordinator and RNs confirmed communication with families are held regarding restraint and enabler use, and discussions were held around reducing or minimising any restraint.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Quality review of restraint is managed through the internal audit programme and the restraint meetings. Review of documentation and interview of the restraint coordinator confirmed this.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	<p>PA</p> <p>Moderate</p>	<p>The facility is managed by new CEO who started employment on the 1 March 2021. Prior to that, the chairman of the trust board has been acting as the interim CEO since October 2020 when the last CEO left. The new CEO is a qualified chartered accountant and has an extensive background in management and financial services, both in NZ and offshore. The CEO is new to the aged care sector and is supported by the trust board, especially the chairman, the relieving clinical nurse manager (RCNM) and other senior staff.</p> <p>A relieving CNM has been employed on a fixed term contract of six weeks while the current CNM is on planned leave, the length of which is not known. The relieving CNM has been in the position for two weeks at the time of audit. The relieving CNM is an experienced clinical nurse manager who has worked in similar positions in other aged care facilities in the area and recently has been contracting to aged care facilities as a nurse consultant.</p> <p>The last CNM left employment in January 2020. There was no CNM until</p>	<p>The current CNM who is on leave does not have experience relating to the role of a clinical nurse manager and did not receive an orientation/ induction to the role. Staff reported there has been a lack of direction and leadership, however, the experienced RNs and ENs ensured residents continued</p>	<p>Provide evidence that robust clinical governance will be maintained long term once the contract for the relieving clinical nurse manager finishes.</p>

		<p>April 2020 when the current CNM was recruited from within the workforce. The position was not advertised. The current CNM does not have experience for the role of CNM and the responsibilities that are expected. Prior to this position the CNM was an RN on the floor working part-time for three shifts a week. Senior staff reported the CNM was not provided with an orientation to the position and review of the CNM's file confirmed this (link to criterion 1.2.7.4). Interviews of all levels of staff evidenced there has been a lack of clinical leadership. Care staff reported they felt unsettled and that the experienced RNs and ENs ensured the care of residents remained safe. All staff interviewed reported even though the relieving CNM has been in the role a short time, they are being supported, have direction and strong leadership.</p> <p>Residents and family members confirmed they are satisfied with the care provided.</p>	to receive safe care.	60 days
<p>Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>An orientation workbook is generic and role specific and includes competencies. The workbook is completed within three months of employment. Staff performance is reviewed at the end of this period. Orientation for staff covers all essential components of the service provided. Four of the 10 staff files reviewed did not have a completed orientation on file. The quality assurance coordinator reported they knew that two of the four staff have completed an orientation; however, they have not handed the documentation in for filing.</p>	Four of the 10 staff files reviewed did not evidence a completed orientation.	<p>Provide evidence that all staff have a completed orientation on file.</p> <p>60 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	<p>The in-service education programme is the responsibility of the CNM; however, with the disruptions including Covid 19 and a period without a CNM, ongoing training has been spasmodic. Staff and the QAC interviewed confirmed this. 'Toolbox talks' at handover, specific topics relating to individual resident's health status and one to one training has been provided, however, these have not been recorded. Attendance at training sessions is entered into the electronic spread sheets and evidenced attendance at sessions that have been held is poor, apart from the session on bullying. The local DHB provides education sessions for RNs. Individual records of education are held on staff files and electronically. The relieving CNM reported they are currently reviewing the in-service training programme and</p>	Ongoing training for staff has been spasmodic during 2020 and 2021 and attendance at sessions is generally poor. The RCNM is currently reviewing the way training is provided and intends seeking input from	Provide evidence that the in-service education programme is followed, restraint competencies are current and that attendance at

		the way it is provided with a view to increasing attendance. Medication competencies were current. Restraint competencies were not current. Of the nine RNs, two are interRAI trained as well as the RCNM. All RNs, ENs and other staff have current first aid certificates.	staff so that attendance is increased. Restraint competencies are not current.	sessions has increased to an acceptable level. 60 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	<p>The two areas in the facility are separated with the hospital accommodating 19 residents who are mainly hospital level and the rest home area 33 residents who are mainly rest home level, with three at hospital level who require two staff to hoist. An acuity tool is used to gauge dependency levels of residents and a documented rationale for determining staffing levels and skill mix to provide safe service is in place. The relieving CNM reported the rosters are reviewed continuously and dependency levels of residents and the physical environments are considered.</p> <p>Interviews of senior staff, caregivers, RNs and ENs evidenced staff are struggling to safely care for residents as the acuity levels have increased, especially in the rest home area. Staff reported that while they are occupied, residents are preparing for bed themselves and falling. Quality data relating to resident falls evidenced a spike between 7pm and 8pm at night in the rest home area. Staff reported an additional staff member is required on the afternoon shift to 'float' between the two areas. The relieving CNM is aware of this and is currently reviewing the roster.</p>	The acuity levels of residents have increased particularly in the rest home area and the staffing levels on the afternoon shift have not been increased to manage this. Quality data evidenced the rate of falls is highest between 7pm and 8pm and staff reported they are struggling to cope.	Provide evidence that staffing on the afternoon shift is increased to safely manage the care of residents, especially at peak times such as settling residents for the night, when falls are at their highest rate. 30 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes	PA Moderate	<p>Nine of nine files reviewed had long term care plans in place; however, two of the nine files reviewed had no interRAI assessment completed eight weeks post admission. Evidence verified there is only two interRAI trained RNs (excluding the CSM) at Tainui to complete the interRAI assessments.</p> <p>Six of the nine files reviewed did not have the documentation in place that described fully the residents' needs. Three residents' files had not been updated to reflect the change in care status from rest home to hospital. Care</p>	Care plans reviewed did not always describe fully the required support the resident needed, to achieve the desired outcomes identified	Provide evidence that care plans describe fully the required support the resident

<p>identified by the ongoing assessment process.</p>		<p>plans were not updated in line with changing needs and did not reflect the resident's present needs (e.g., pain management strategies, weight loss management, mouth care management, and diabetic management). Short term care plans were instigated when a resident had an infection or a wound; however, not for any other short-term problems, for example, changes in medications, potential postural hypotension (requiring blood pressure monitoring). Behaviour management strategies were not evidenced to be documented fully in the behaviour management plan about new medications introduced and monitoring for their effectiveness.</p>	<p>by the assessment process.</p>	<p>requires to achieve the desired outcomes, as identified by the assessment process.</p> <p>180 days</p>
<p>Criterion 3.1.1 The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.</p>	<p>PA Moderate</p>	<p>The ICC role at Tainui has in the past been viewed as part of the CNM role. There was no CNM at Tainui from January 2020 until April 2020, and when the new CNM was recruited, the job description did not include the infection control coordinator role. As a result of this, there has been no one formally appointed to manage the IPC at Tainui. New staff have had no infection control training, other than that provided by the person who works alongside them in the training role. Incidents of infections are reported at the monthly meetings by the quality assurance coordinator; however, no formal analysis has been undertaken. Onsite training, and risk management strategies around Covid-19 has occurred as toolbox sessions daily, as per the information guidelines provided by the Ministry of Health, however this has not been recorded anywhere. Apart from this no formal training around infection control has occurred at Tainui in the past year. There is no evidence of handwashing or infection control audits being carried out in the past year.</p>	<p>Up until a week prior to audit there has been no infection control coordinator at Tainui since January 2020, to ensure there is a managed environment to minimise the risk of infections to residents, staff, and visitors.</p>	<p>Provide evidence the responsibility for infection control is clearly defined and that there is a managed environment that minimises the risk of infections to residents, staff, and visitors.</p> <p>180 days</p>

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

No data to display

End of the report.