

Millvale House Miramar Limited

Current Status: 22 May 2014

The following summary has been accepted by the Ministry of Health as being an accurate reflection of the Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.

General overview

Dementia Care New Zealand (DCNZ) is the parent company to Millvale House. Millvale House is managed by an operations manager with support from a clinical manager, registered nurses and care staff. Organisational support is provided by the two DCNZ directors, a general manager, an education coordinator, a quality systems manager, and a regional clinical manager. The service is certified to provide psychogeriatric hospital level care in a 26 bed unit and rest home level care for one resident. Current occupancy is 26 psychogeriatric residents and one rest home resident.

The service has an implemented quality and risk management system in place to ensure that care and services are provided to residents in line with their assessed needs. The service has addressed three of three shortfalls from the previous certification audit around establishing links with local Iwi/Tangata Whenua, use of corrective action plans following internal audits and use of short term care plans.

This audit identified that no further improvements are required.

Audit Summary as at 22 May 2014

Standards have been assessed and summarised below:

Key

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
	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

Indicator	Description	Definition
	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

Consumer Rights as at 22 May 2014

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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Organisational Management as at 22 May 2014

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.		Standards applicable to this service fully attained.
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Continuum of Service Delivery as at 22 May 2014

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 22 May 2014

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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Restraint Minimisation and Safe Practice as at 22 May 2014

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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Infection Prevention and Control as at 22 May 2014

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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HealthCERT Aged Residential Care Audit Report (version 4.0)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

Audit Report

Legal entity name:	Millvale House Miramar Limited
Certificate name:	Millvale House Miramar Limited
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Surveillance Audit
Premises audited:	Millvale House Miramar
Services audited:	Hospital services - Geriatric services - psychogeriatric; Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 May 2014 End date: 23 May 2014
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	27

Audit Team

Lead Auditor	XXXXX	Hours on site	11	Hours off site	5
Other Auditors		Total hours on site	0	Total hours off site	0
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	1

Sample Totals

Total audit hours on site	11	Total audit hours off site	6	Total audit hours	17
Number of residents interviewed	1	Number of staff interviewed	9	Number of managers interviewed	3
Number of residents' records reviewed	5	Number of staff records reviewed	5	Total number of managers (headcount)	3
Number of medication records reviewed	10	Total number of staff (headcount)	27	Number of relatives interviewed	2
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of Health and Disability Auditing New Zealand Limited	Yes
b)	Health and Disability Auditing New Zealand Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	Health and Disability Auditing New Zealand Limited has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Yes
g)	Health and Disability Auditing New Zealand Limited has provided all the information that is relevant to the audit	Yes
h)	Health and Disability Auditing New Zealand Limited has finished editing the document.	Yes

Dated Monday, 16 June 2014

Executive Summary of Audit

General Overview

Dementia Care New Zealand (DCNZ) is the parent company to Millvale House. Millvale House is managed by an operations manager with support from a clinical manager, registered nurses and care staff. Organisational support is provided by the two DCNZ directors, a general manager, an education coordinator, a quality systems manager, and a regional clinical manager. The service is certified to provide psychogeriatric hospital level care in a 26 bed unit and rest home level care for one resident. Current occupancy is 26 psychogeriatric residents and one rest home resident. There were no respite residents on the day of audit. The service has an implemented quality and risk management system in place to ensure that care and services are provided to residents in line with their assessed needs.

The service has addressed three of three shortfalls from the previous certification audit around establishing links with local Iwi/Tangata whenua, use of corrective action plans following internal audits and use of short term care plans.

This audit identified that no further improvements are required.

Outcome 1.1: Consumer Rights

The previous finding relating to links with local Maori has now been addressed and monitored. The service has access to a local Kaumatua who has reviewed and signed off the Maori health plan. The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion were viewed on the family notice board in the entrance foyer to the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

Outcome 1.2: Organisational Management

The quality and risk programme includes a variety of quality improvement initiatives which are generated from meetings, resident, family and staff feedback and through the internal audit systems. Millvale House has a current business and quality plan to support quality and risk management at each facility. Millvale House implements an internal audit programme and collates data for comparisons against other Dementia Care NZ facilities. The service has addressed and monitored previous finding relating to use of corrective actions following internal audits. There is also a benchmarking programme in place across the organisation. Relative surveys are undertaken annually. Incidents and accidents are appropriately managed. Staff requirements are determined using an organisation service level/skill mix process and documented. There is a documented rationale for staffing. Duty schedules are available for all shifts. Staffing rosters indicate there is suitable staff on duty to care for residents. The service has a documented and implemented training plan.

Outcome 1.3: Continuum of Service Delivery

A registered nurse is responsible for each stage of service provision. The development of the nursing care plans, activity plans and evaluations are reviewed in consultation with the resident/family/whanau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care. Three monthly multidisciplinary reviews involve the GP, allied health professionals and resident/family. Short term care plans are used for short term issues. The service has addressed and monitored this previous finding.

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding

NZS 8134.1:2008: Health and Disability Services (Core) Standards

Outcome 1.1: Consumer Rights

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.4: Recognition Of Māori Values And Beliefs (HDS(C)S.2008:1.1.4)

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.

ARC A3.1; A3.2; D20.1i ARHSS A3.1; A3.2; D20.1i

Attainment and Risk: FA

Evidence:

Previous certification audit identified that a consultative process with local iwi/Tangata whenua and on-going monitoring process was not yet established (#1.1.4.6). The services' policies and procedures provide evidence that appropriate Maori cultural services are able to be accessed. There is currently one psychogeriatric resident who identifies as Maori. The service has links with a local Kaumatua who has reviewed and approved the Maori health plan, and a local Te Kohanga Reo. Bi-cultural awareness education has been provided for staff in March 2013. The service has addressed and monitored this previous shortfall.

Standard 1.1.9: Communication (HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

Attainment and Risk: FA

Evidence:

There is an open disclosure policy in place, information on which is included at the time of admission. The policy states residents or their representative have the right to full and open disclosure. Incident and accident forms are completed by either caregivers or registered nurses and a copy of any incident relating to individual residents is included in the clinical file. The incident form and resident summary form records that families or next of kin are informed following incidents or accidents or if there is a change in resident condition (confirmed by two psychogeriatric relative interviews). Notification of next of kin for the incident reports sampled was confirmed through the clinical files reviewed. Copies of completed admission agreements are held in the main office and an extensive admission booklet is given to all new residents and or family. There is an interpreter policy in place with information included in the admission booklet.

D12.1 Non-Subsidised residents are advised of the process and eligibility to become a subsidised resident through the admission booklet.

D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the admission agreement and admission booklet. A site specific introduction to the psychogeriatric unit booklet provides information for family, friends and visitors visiting the facility is included in the admission pack.

D16.4b Residents (one) and relatives (two) interviewed confirmed they are kept fully informed.

D11.3 The admission booklet is available in large print and can be read to residents if required.

Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)

Consumers have a right to full and frank information and open disclosure from service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)

Wherever necessary and reasonably practicable, interpreter services are provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.1.13: Complaints Management (HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

Attainment and Risk: FA

Evidence:

The complaints process and forms for completion are available at the entrance foyer of the facility. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. A review of complaints received for the past 12 months was conducted. A record of outcomes is recorded within an electronic complaints register. The complaints register records the details of the complaint, date of corrective actions taken and signed off when resolved. A complaints folder contains all documentation for the two complaints received for 2013 and one for 2014. Details of the management of the complaints is recorded including letters of follow up and response. Complaints are discussed at the monthly quality management meetings, at organisational level and at three monthly staff meetings.

D13.3h. a complaints procedure is provided to residents within the information pack at entry.

ARHSS D13.3g: The complaints procedure is provided to relatives on admission.

Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

Attainment and Risk: FA

Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.2: Organisational Management

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

Standard 1.2.1: Governance (HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

Attainment and Risk: FA
<p>Evidence:</p> <p>Dementia Care NZ is the parent company for Millvale House . There is an organisational wide quality and risk management plan which includes strategic and business objectives for 2013-2014. The governance structure includes two owners/directors. Millvale House is managed by an operations manager and a clinical manager. Managers from all facilities report daily to the general manager of Dementia Care NZ. The operations manager has been in the role for two and a half years and has previously worked for the organisation as a caregiver. She has qualifications in nursing (overseas trained), and dementia care. The clinical manager (registered nurse) is responsible for the clinical oversight of the service. The clinical manager has been in the role at Millvale house for three weeks, having worked for the company at another facility for the past year. The operations manager and clinical manager are also supported by an organisational quality systems manager, a regional clinical manager and an education coordinator.</p> <p>The vision and values of the organisation underpin the philosophy of the service which includes ‘creating a loving, warm and homely atmosphere where each person is supported to experience each moment richly”. 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.</p> <p>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.</p>

Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.3: Quality And Risk Management Systems (HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

Attainment and Risk: FA
Evidence: Dementia Care NZ has an organisational wide quality and risk management plan for 2013 – 2014 which includes strategic and business goals and objectives. The 39 goals cover all aspects of service and includes implementing the vision and values, providing specialist dementia care, providing a homely atmosphere, education and training for staff, education and support for family, human resource management, occupancy, finance, consumer rights, communication, policies and procedures, restraint use, infection control and benchmarking. The operations manager reports daily to the general manager of Dementia care NZ. A quality systems manager provides quality management support to the operations manager with updates and reviews of policy manuals and oversees the quality management programme. Quality improvement initiatives for Millvale House have also been documented and are developed as a result of feedback from residents and staff, audits, benchmarking, and incidents and accidents. These are reviewed at the monthly quality management meetings for effectiveness of implemented actions. Risk management plans are in place for the organisation and there are specific plans for risk and hazard management for the facility and include health and safety, staff safety, resident safety, external environment, chemical storage, kitchen, laundry and cleaning.

Progress with the quality and risk management programme is monitored through the monthly quality meetings, three monthly staff meetings, monthly health and safety meetings, monthly registered nurse meetings and monthly infection control meetings. Monthly and annual reviews are completed for all areas of service and include infection rates, incidents and accidents, restraint use, internal audits, complaints, and health and safety. The monthly quality committee meeting agenda includes (but is not limited to): previous meetings minutes and outstanding issues, reports re: internal audits, infection control, health and safety, incidents and accidents, staff, family interaction, clinical report, marketing, activities and education. Minutes are maintained (sighted for 24 April 2014) and staff have access to these meeting minutes in the staff room (confirmed by five care givers at interview). Registered nurse meeting agenda covers clinical issues, medication errors, education sessions and general business. Minutes for all meetings include actions to achieve compliance where relevant and quality improvements are initiated. This, together with staff training, demonstrates Millvale House's commitment to on-going quality improvement. Discussions with one registered nurse and five care givers confirm their involvement in the quality programme. Resident/family meetings take place monthly with laundry, activities and food/meals as regular agenda items. Minutes sighted for 15 April 2014. There is an internal audit schedule. It includes (but is not limited to): operations audits covering complaints, environmental safety, kitchen service, laundry, staff files, privacy of information; and clinical audits covering general practitioner care, infection control, medication management, pressure area assessment, resident care, resident files, care planning, and restraint.

The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.

There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures.

There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.

The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the resident care plans. The directors, the general manager, quality system manager and regional clinical managers are responsible for development and review of policies and procedures. Death/Tangihanga policy and procedure in place that outlines immediate action to be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner. There are procedures to guide staff in managing clinical and non-clinical emergencies and there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. Falls prevention strategies such as falls risk assessment, medication review, education for staff, residents and family, physiotherapy assessment, use of appropriate footwear, falls review, correct seating, increased supervision and monitoring and sensor mats if required.

The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by care givers and given to the registered nurse who completes the follow up including resident assessment, treatment and referral if required. All incident/accident forms are seen by the clinical manager and operations manager who complete any additional follow up. The operations manager collates and analyses data to identify trends. Results are discussed with staff through the three monthly staff meetings, monthly health and safety meetings, and monthly quality meetings.

Internal audits for 2013 and 2014 (year to date) have been completed and there is evidence of documented management around non-compliance issues identified. Finding statements and corrective actions have been documented. Quality improvements are raised where there is an identified short fall in internal audit outcomes. The service has addressed and monitored this previous finding. A family/EPOA survey conducted in March 2014 attracted a 50% return rate. The annual survey evidences that families/NOK/EPOA are over all very satisfied with the service. Survey questions included feedback on staff, medical care, activities, cleaning and laundry, complaints process, food, environment and overall impression. Survey evaluations have been conducted for follow up and quality improvements developed where required. Residents and families are informed of survey outcomes via meetings and newsletter sent to all family with the survey outcomes. Corrective actions and quality improvements are developed following all meetings, audits, surveys, with evidence of actions completed and sign off of all required interventions.

Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)

The organisation has a quality and risk management system which is understood and implemented by service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)

Key components of service delivery shall be explicitly linked to the quality management system.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)

A process to measure achievement against the quality and risk management plan is implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:

- (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;
- (b) A process that addresses/treats the risks associated with service provision is developed and implemented.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.4: Adverse Event Reporting (HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

Attainment and Risk: FA
Evidence: <p>There is an incident reporting policy. Incidents, accidents and near misses are investigated and analysis of incidents trends occurs. There is a discussion of accidents/incidents at monthly quality committee meetings, monthly health and safety meetings, and three monthly staff meetings including actions to minimise recurrence. Discussions with the service confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is an open disclosure policy and two family members interviewed stated they are informed of changes in health status and incidents/accidents. A sample of incidents for May 2014 involving five residents were reviewed and included three falls, one skin tear, two behaviours and one pressure area. Reports were completed and family notified as appropriate. There is documented evidence of clinical follow up by a registered nurse with review of all reports by the clinical manager. Monthly incident/accident collation and analysis occurs with subsequent annual summary and analysis. Medication errors are also reported. An electronic monthly summary of accidents and incidents is compiled by the operations manager with subsequent analysis and investigations. Trends and corrective actions are developed for staff to continue to improve on falls rates and to implement actions for falls prevention. There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Staff are informed of incidents and accidents and actions to prevent reoccurrence through communication books, hand over times and have access to meeting minutes.</p>

Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.2.7: Human Resource Management (HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

Attainment and Risk: FA
Evidence: The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates including the registered nurses, dietitian, physiotherapist, podiatrist, pharmacists and general practitioners is kept. There are comprehensive human

resources policies including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (operations manager, clinical manager, one registered nurse/ infection control nurse, and two care givers. Advised that reference checks are completed before employment is offered as evidenced in three recently employed staff files reviewed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Five care givers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Orientation checklists evident in five of five staff files reviewed.

Discussion with the registered nurses and caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is a completed in-service calendar for 2013 and year to date for 2014 and a plan in place for the remainder of 2014. The annual training programme exceeds eight hours annually. Caregivers have completed either the national certificate in care of the elderly or are working towards completion. All care givers are expected to complete the dementia unit standards – with 12 of 16 care giving staff having completed, three staff working towards completion and one yet to start (commenced employment in the past month). The diversional therapy staff (two) have completed ACE dementia modules. The orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.

The operations manager and clinical manager, and registered nurses attend external training including conferences, seminars and sessions provided by the local DHB, the organisation and the New Zealand Aged Care Association. The operations manager has attended the organisations management training day in April 2013.

Education provided in 2013 includes but not limited to: manual handling, fire training, intercultural awareness, communication, vision and values of the organisation, non-violent crisis intervention, dementia, restraint minimisation, continence, bi-cultural awareness, complaints process, infection control, civil defence and emergency management, and managing challenging behaviours. Dementia care NZ also has a number of competency packages which have been developed for care staff and registered nurses. Staff complete self-directed learning packages if they are unable to attend education sessions. There are compulsory competencies for staff which include medication, restraint minimisation, non-violence crisis interventions, infection control, cultural awareness, abuse and neglect, chemical safety, first aid, and fire safety. Registered nurses also complete specific competencies around medications, assessments, delirium, neurological care, and skin and pressure area care. All staff are encouraged to complete the service's 'best friends approach to care' package which is aimed at providing staff with the skills to care for residents as their 'best friend'. The operations manager maintains a spread sheet to record all education provided, attendance and competencies completed. Families are also provided with education and support with two programmes offered - 'orientation for families' and 'sharing the journey'. These programmes are designed for dementia resident's families to provide education, understanding and coping with dementia progression, understanding behaviours, and responding to behaviours.

Fire safety education was provided in August 2013 with a six monthly fire evacuation drill (last conducted on 25 February 2014). Annual appraisals are conducted for all staff as evidenced in five of five files reviewed.

Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)

The appointment of appropriate service providers to safely meet the needs of consumers.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

Attainment and Risk: FA
Evidence:
Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.2.8: Service Provider Availability (HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

Attainment and Risk: FA

Evidence:

The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Rosters are in place and show staff coverage across the psychogeriatric unit. There is a registered nurse on duty in the unit 24/7. This registered nurse is available for psychogeriatric residents and the rest home resident (under mental health contract). Sufficient staff are rostered on to manage the care requirements of the residents. A minimum of three staff are rostered on at any one time – one registered nurse and two caregivers. The unit is divided in to two wings of 13 beds – with a large communal lounge and dining/kitchenette area in the middle. The operations manager works full time and the clinical manager works full time providing clinical administration and rostered registered nurse shifts. Care givers on morning and afternoons work a mixture of short and long shifts. There is a designated cleaning and laundry person. Other staff include diversional therapist and activities staff, kitchen staff and maintenance and gardening staff. There are two activities staff rostered on each day (Monday to Sunday) and cover 1030 hours to 1730 hours. Interviews with one registered nurse, five care givers, one rest home resident and two family members identify that staffing is adequate to meet the needs of residents.

Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Outcome 1.3: Continuum of Service Delivery

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.

Standard 1.3.3: Service Provision Requirements (HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

Attainment and Risk: FA

Evidence:

Millvale House provides a caring homely environment for its residents. The service provides psychogeriatric level of care for 26 residents in two 13 bedroom 'homes' – Loloma and Kaibigan - within a secure unit. Upstairs there is office space and a staff room and one rest home level resident room. Previously there had been two rest home residents residing upstairs, however, with the transfer out of one resident, the service has converted the room to office space.

The staff are committed to valuing each resident as an individual and practice the "best friends" approach to care and activities. Establishing relationships with families is achieved with community visits and bringing together families through "sharing the journey" family support groups. Two relatives interviewed (psychogeriatric) spoke highly of the management and staff, the care, activities programme, medical care and the environment.

D16.2, 3, 4. Four psychogeriatric and one rest home files sampled, identified that in all five files an assessment was completed within 24 hours and all five files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed three monthly by a registered nurse (RN) and amended when current health changes. There are three monthly multidisciplinary (MDT) reviews for all residents.

D16.5e; Five resident files sampled identified that the general practitioner (GP) had seen the resident within two working days. It is noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly or more frequently should the residents health status change.

The resident may retain their own GP. There is a house GP who visits the service at least twice a week (as advised on interview). This GP has the majority of residents. Other GP's also visit and conduct three monthly consultations for routine three monthly medical examination and medication reviews. The main GP (interviewed by phone) spoke positively about the care and level of services provided at Millvale House. The RN's are knowledgeable about the resident conditions and assist the GP during the routine and after hour's visits. A geriatrician also provides services to the residents of Millvale house when needed. There are no residents currently under routine care of psychogeriatric services but are available when required and requested. Advised by the registered nurse that all residents are currently stable and that staff are able to manage any challenging behaviours. Advised that assistance and support by allied health services is available when needed.

The physiotherapist visits fortnightly and completes the initial assessments and mobility plans for new residents, attends MDT reviews, and provides follow-up on any concerns/referrals regarding deteriorating mobility, assessment/purchase of equipment. The podiatrist visits six weekly.

The dietitian visits monthly and is involved in resident reviews where applicable and readily available (by visit and email) to the clinical and food services team for any advice or resources. Allied health professionals record visits in the integrated notes. Nurse specialists such as wound, continence, community mental health nurses are accessed through the local DHB.

The hospice nurses and specialists visit residents under their care for specific needs and palliative cares.

Five caregivers and one RN interviewed described verbal and written handovers. The information given at handover is sufficient to provide continuity of care to the residents and includes significant events such as incidents/accidents, changes in condition, GP visits and medication changes. A communication log is used between all staff for general memos. The RN's state caregiver progress notes are reviewed and evidenced by a review stamp. The caregivers are very prompt in reporting any resident health changes or incidents. A resident daily hygiene cares and bowel chart is maintained for every resident. There are daily security check lists maintained.

ARHSS D16.6; Four residents file sampled with behaviours that challenge were reviewed. Behaviours are well identified through the assessment process, 24 hour MDT management plan, resident behaviour chart and behaviour monitoring.

The organisational education coordinator is a trained psychiatrist nurse and is readily available to staff for advice, education and staff debriefs as required.

Tracer methodology:

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Tracer methodology:

XXXXXX *This information has been deleted as it is specific to the health care of a resident.*

Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.6: Service Delivery/Interventions (HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

Attainment and Risk: FA
Evidence: <p>The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussion with caregivers, registered nurses, activity staff and management. The care plans are well written, in-depth and reflect the service philosophy of care and support. Relatives interviewed states their relatives needs are being met. The staff and facilities are appropriate for providing psychogeriatric services. There is evidence of good use of short term care plans. The long term care plan and activities of daily living care plan reflect the current care requirements of residents as evidenced in five of five care plans reviewed. The service has made improvements in this area.</p> <p>D18.3 and 4. Wound assessment forms are comprehensive and include type, location and body map/graph, photograph as applicable, Braden score, cause, and classification, factors delaying healing and any additional information such as referrals. A wound dressing schedule describes dressing types, objectives and reviews. There are wound assessment plans and wound dressing schedules in place for one resident with a sacral pressure area. Pressure area resources are available as required. The service has access to district nursing wound management support if required. Continence management advice is available as needed (through the DHB) and this could be described by the clinical manager and registered nurse interviewed. Adequate dressing supplies are sighted. Continence assessments include a urinary and bowel continence assessment are completed on admission and reviewed three monthly. Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained.</p> <p>ARHSS D16.6; Five residents file sampled with behaviours that challenge were reviewed. Behaviours are well identified through the assessment process, 24 hour MDT management plan, resident behaviour chart and behaviour monitoring.</p> <p>Community mental health, psychiatric nursing service and a psychogeriatrician are readily accessible. The psychogeriatrician visits as required. There is evidence in the medical notes of GP communication with the psychogeriatrician in regards to medication review.</p> <p>Pain assessments (Abbey pain scale) are available for the assessment of identified pain on admission, new episodes of pain and for residents on regular or prn medication. Pain assessments and ongoing pain monitoring is evident in the files sampled. Pain management and pain relief is reviewed three monthly by the GP and MDT team.</p> <p>The dietitian visits monthly and completes any resident reviews due and attends to any referrals received for example residents with weight loss, initiates special authority</p>

for supplements and liaises with the RN regarding any resident dietary changes/requirements. Residents are weighed monthly or more frequently as per the weight loss management policy. The dietitian maintains progress notes in the integrated resident file. Staff record food and beverage intake on recording charts. Prescribed dietary supplements administered are signed on the nutritional supplement signing chart in the medication folder.

Frequent falls physiotherapy assessments are carried out as required. The physiotherapist attends fortnightly. Falls risk and interventions are well documented in care plans that include sensor mats, hip protectors, adequate hydration, clutter free environment and good fitting shoes. Mobility and handling plans are reviewed regularly to guide the staff in the safe transfer of residents. Frequent fallers are reviewed by the MDT team. Use of psychotropic medications have been reduced to minimise side effects and are monitored by the GP.

Monitoring forms in use included behaviour monitoring, weight monitoring, food and fluid monitoring and AWOL charts. RN faxes to GPs regarding changes in resident health status, suspected infections, new admission, and medication requests sighted in the resident files sampled. Daily walking resident at risk charts are in place that identify the clothing being worn for that day.

Significant events record relative/EPOA contact or discussion such as care plan reviews, infections, incidents/accidents, GP visits, allied health professional visits, medication reviews and any changes in resident health status.

Challenging behaviour assessments are well documented with excellent follow up into care plans for the four psychogeriatric resident files sampled and one rest home resident file with identified behavioural issues. Behaviour monitoring forms are used to record behavioural or disruptive actions and describe distraction techniques. All resident files sampled have a 24 hour MDT (multidisciplinary) care plan that details the resident's morning and afternoon habits, behaviours, activities or diversions that work, nocte pattern, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation.

ARHSS D16.4; There is specialist input into residents in the psychogeriatric unit. Strategies for the provisions of a low stimulus environment could be described by the care team and activities staff.

Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.7: Planned Activities (HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

Attainment and Risk: FA

Evidence:

The company diversional therapy (DT) team leader is employed for four days as a DT and oversees and supports the activities teams in all Dementia Care N.Z. facilities. The activity staff at Millvale House are employed for a total of 73.5 hours a week. One activities staff member is the process of completing her diversional therapy qualifications and is an overseas trained registered nurse. Four other caregiving staff members provide activities and have completed activities training and dementia care unit standards. There is one activities staff assigned on each day of the week from 10.30am until 5.30pm and another from 1.30pm until 5.30pm. The activity team are kept informed of resident's health, mobility and cognitive status by reading the handover sheets and accident/incident reports.

The team meet monthly to plan the programme for the residents. Activities include a mixture of group activities and one on one time with residents. Activities plans are individual and include a social history, goals, plans and evaluations.

The 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, arts and crafts, van outings, church services, exercises and happy hour. Regular entertainment is scheduled. There are community volunteers who visit and share skills such as pottery, assist with resident shopping and other activities. Ethnic and cultural preferences are met as evidenced in the activity care plans sampled. There are weekly van outings. The wheelchair taxi is used as required.

Activity assessments, activity plan, 24 hour MDT plan, progress notes and attendance charts are maintained. Resident meetings are held monthly.

ARHSS 16.5g.iii: A comprehensive social history is complete on or soon after admission and information gathered from the relative (and resident as able) is included in the activity care plan. The activity care plan and 24 hour MDT care plan is reviewed at least six monthly. Weekly progress notes are written into the integrated notes.

ARHSS 16.5g.iv: Caregivers are observed throughout various times through the day diverting residents from behaviours. The caregivers integrate activities into the resident activities of daily living.

D16.5d Resident files reviewed identified that the individual activity plan is reviewed when at care plan review.

Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Standard 1.3.8: Evaluation (HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

Attainment and Risk: FA

Evidence:

Nursing care plans are reviewed and evaluated three monthly by the MDT team psychogeriatric and rest home residents. The MDT include the nursing and care staff, DT, physiotherapist, resident/family/whanau/EPOA as appropriate. Other health professionals are involved as appropriate. Short term care plans are used for short term care issues as evidenced in five files reviewed for infections, post cataract surgery, constipation, cellulitis, and skin tears. Short-term care plans are reviewed as required and are resolved and signed off or if an ongoing problem, added to the long term care plan. There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes. There is evidence of on-going review and changes to care plans.

The three monthly written review covers resident recordings (weight, blood pressure, and pulse), physical examination, restraint (if applicable), behaviour, family discussions, medication review and falls (if relevant).

ARHSS D16.3c: All initial care plans were evaluated by the RN within three weeks of admission.

D16.4a Care plans are evaluated at least six monthly more frequently when clinically indicated.

Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

Timeframe (days): *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.12: Medicine Management (HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i.i.2; D18.2; D19.2d

Attainment and Risk: FA
Evidence: <p>The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice including, but are not limited to: a) medication management, b) medication charting c) standing orders, d) medication storage, e) blister pack management, f) medication administration, g) specific medication devices (such as spacers, oxygen, IV therapy, sub-cut fluid administration, novo-pen, etc.) h) medication errors, i) emergency medications, j) staff training, k) storage and administration of controlled drugs, l) alternative medication and m) medication audit. There is one main locked medication room which contains the medication trolley, PRN medications, dressing requirements and the controlled drugs safe.</p> <p>The service uses a robotic sachet pack system for regular and PRN medications. The RN checks the packed medications on arrival from the supplying pharmacy. Medication reconciliation is implemented via the 'medication management on admission and transfer policy'. Medications are administered to all residents by registered nurses only. Orientation to medications include a self-learning package and supervised medication rounds. Annual competency and medication education has been completed. Standing orders are in use with evidence of annual review by GP's. There is an emergency pharmacy stock of medications. The controlled drugs register evidences weekly controlled drug checks. Controlled drugs administered are signed by two staff members. There is a six month pharmacy audit dated December 2013. All eye drops in use are dated on opening. The medication fridge is monitored and recorded daily.</p> <p>The medication folder contains specimen signature list, signing sheets for nutritional supplements, alert labels for medications and duplicate name. There are no self-medicating residents. All prn medications are dated and timed. Prn medications prescribed have an indication for use.</p> <p>Medication charts had current (dated) photo identification and allergies noted. Special medication instructions and precautionary advice is recorded on the medication charts.</p> <p>D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed.</p>

Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)

A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)

The facilitation of safe self-administration of medicines by consumers where appropriate.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management (HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

Attainment and Risk: FA
Evidence: <p>There is a kitchen service manual located in the kitchen which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. There is a cook on duty each day from 6.45am to 5.15pm to prepare, cook and serve the meals. A tea aide is on duty from 16.45pm to assist with the evening meal, supper and cleaning duties. All staff have attended food safety and hygiene, chemical safety, first aid and relevant in-service offered on-site. The kitchen is located within the psychogeriatric unit and is locked via a combination lock so that only staff can access this area. There is a kitchenette where food is dished up to residents. Containers of food are transported in hot boxes to the kitchenettes where caregivers plate and serve the meals.</p> <p>There is a four weekly winter and summer menu in place that has been reviewed by the company dietitian in April 2013. All cooking for and baking is done on site. 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. Lip plates and specialised utensils are available as needed to promote independence at meal times. There are additional nutritional snacks available for residents including (but not limited to): sandwiches, jellies, instant puddings, fruit and biscuits. There are adequate fluids sighted in the kitchenette fridges and protein drinks are available. All facility fridges have temperatures recorded daily.</p>

There is daily monitoring of hot food temperatures, fridge and freezer temperatures, dishwasher rinse temperatures and delivery temperatures for chilled/frozen goods. All perishable foods in the kitchen fridges and freezer are dated. The dry good store have all goods sealed and labelled. Goods are rotated with the delivery of food items. The cook is observed wearing appropriate personal protective clothing. There are fly screens on the windows. Chemicals are stored safely within the kitchen. There are safety data sheets available. Weights are monitored monthly or more frequently if required. Residents assessed by the dietitian who require supplements received these and this is recorded in the resident's file. One resident with a PEG receives nutritional supplementation which is recorded. There is evidence of PEG care and replacement.
 ARHSS D15.2f; There is evidence that there is additional nutritious snacks available over 24 hours for the psychogeriatric residents.

Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

Standard 1.4.2: Facility Specifications (HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

Attainment and Risk: FA
Evidence: The facility displays a current building warrant of fitness which expires on 29 June 2014. There is sufficient linen and of reasonable quality sited at the facility. There was adequate bedding in a number of resident rooms

Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)

All buildings, plant, and equipment comply with legislation.

Attainment and Risk: FA
Evidence:

Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

Standard 2.1.1: Restraint minimisation (HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA
<p>Evidence:</p> <p>There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. The service currently has nine residents assessed as requiring restraint (all psychogeriatric residents). Six residents have hand holding restraint, one has a T-belt restraint, one has hand holding and a T belt and one has bed rails. There are no residents at Millvale House with enablers. Policy dictates that enablers should be voluntary and the least restrictive option possible. The clinical manager, one registered nurse and five caregivers are familiar with restraint minimisation policy and restraint practices used. The restraint coordinator (regional clinical manager) was conversant with restraint minimisation and in managing challenging behaviours. A restraint register is maintained. The restraint register was reviewed. Hand holding restraint is only used during personal cares and for a maximum of 10 minutes; T-belts are monitored every 15 minutes; and bed rails are used overnight and monitored two hourly. Three resident files with restraint were reviewed (one with bedrails, two with hand holding and T-belt) and evidenced that appropriate documentation is completed including assessments, planning, monitoring, consent and review of restraint. The care plans reviewed focused on promotion of quality of life and minimised the need for restrictive practises through the management of challenging behaviour. Restraint/enabler use is discussed at quality meetings, at health and safety meetings and at registered nurse meetings. Restraint use audit last conducted in January 2014. Staff received training around restraint minimisation and safe practice in March 2013. Management of challenging behaviours education was provided in July and November 2013. Restraint questionnaires and competency are also completed for all care staff.</p>

Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

Standard 3.5: Surveillance (HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

Attainment and Risk: FA
Evidence: <p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality meetings, monthly registered nurse meetings and monthly infection control committee meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the operations manager, clinical manager and to organisational management. A registered nurse at Millvale House is the designated infection control nurse.</p>

Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)

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.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>