# Millvale House Miramar Limited - Millvale House Miramar

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Millvale House Miramar Limited

**Premises audited:** Millvale House Miramar

**Services audited:** Hospital services - Psychogeriatric services; Rest home care (excluding dementia care)

**Dates of audit:** Start date: 22 September 2015 End date: 22 September 2015

**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:** 26

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

## General overview of the audit

Dementia Care New Zealand Ltd is the parent company of Millvale House Miramar. The service provides hospital (psychogeriatric) level care for up to 26 residents and rest home care. On the day of audit, there were 26 residents.

The certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents’ and staff files, observations and interviews with relatives, staff and management.

The quality and risk management plan is being implemented and monitored. Key components of the quality management system link to monthly quality meetings and monthly staff meetings.

An operations manager and a clinical manager manage Millvale House on a daily basis. The operations manager has been in the role for the last four years. The clinical manager (registered nurse) is responsible for the clinical oversight of the service.

The service is commended for achieving a continued improvement rating around good practice.

## Consumer rights

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

Millvale House Miramar has policies and procedures that align with the requirements of the Privacy Act and Health Information Privacy Code. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents’ rights. Annual staff training reinforces a sound understanding of residents’ rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented. A complaints register is maintained.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Dementia care NZ had an established clinical governance group. The service has a well-established quality and risk management system. There were a number of quality initiatives completed at a facility and organisational level. The quality system includes (but not limited to) feedback from the family members with post six monthly surveys, complaints management system, audit results and staff and quality meetings.

Incident/accidents are documented; reporting of incidents occurs and has been monitored with action taken on trends to improve service delivery.

Human resource policies and procedures were implemented. A comprehensive orientation programme provides new staff with relevant information for safe work practice.

There is a comprehensive in-service programme in place, including (but not limited to), specific training around “Best Friends Approach to Dementia Care” and “Non Violent Crisis Intervention training”.

Staff requirements are determined using a documented organisation service level/skill mix process.

## Continuum of service delivery

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

There is a well presented information booklet for residents/families at entry that includes information on the service philosophy, services provided and practices particular to the secure unit. Assessment and care plans are developed by registered nurses and reviewed six monthly by the multidisciplinary team. Families are involved in the development and review of the care plan. A multi-disciplinary team review occurs three monthly. InterRAI assessments are linked into the comprehensive care plan. A 24-hour multidisciplinary care plan identifies a resident’s behaviours and activities or diversions that are successful. There is at least a three monthly resident review by the medical practitioner and psychogeriatric community nurse as required.   
The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident. Individual activity plans are developed in consultation with resident/family.   
The medication management system meets legislative requirements. Registered nurses are responsible for the administration of medications. Education and medication competencies are completed annually. All medications charts have current identification photos and document the resident allergy status. The GP reviews the resident’s medication at least three monthly.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. There is a current building warrant of fitness. Emergency and disaster plans in place guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan and fire drills occur six monthly. Residents were able to move freely inside and within the secure outside environments. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. General living areas and resident rooms are appropriately heated and ventilated. There is staff on duty with a current first aid certificate. The service has policies and procedures for effective management of laundry and cleaning practices.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. The service had no residents using enablers and eight residents using restraints. A register is maintained by the restraint coordinator/RN. Residents using restraints are reviewed a minimum of six-monthly by the approval group. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

## Infection prevention and control

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| --- | --- | --- |
| 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. |

The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The clinical manager and quality team support the infection control coordinator. Infection control training has been provided within the last year. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other dementia care NZ (DCNZ) facilities

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 1 | 49 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 100 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | There is a code of rights policy and procedures in place. The code of health and disability rights is incorporated into care. Discussions with four caregivers identify their familiarity with the code of rights. A review of care plans, meetings and discussion with two family members confirm the service functions in a way that complies with the code of rights. Observation during the audit confirmed this is in practice. Training was last provided on the code of rights and advocacy in June 2015. Code of rights is also included in the staff orientation. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents advance directive where applicable is on file. All resident files reviewed (one rest home and five psychogeriatric) had copies of the EPOA on file.  Interviews with staff and families state they have input and are given choices. Care plans and 24 hours multidisciplinary care plans demonstrate resident choice as appropriate. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The right to access advocacy services is identified for residents/families and is available at the front entrance. The information identifies whom to contact to access advocacy services. Information provided to families prior to entry to the service provides them and family/whānau with advocacy information. Staff are aware of the right for advocacy and how to access and provide advocacy information to relatives/residents if needed and training has been provided. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has open visiting hours. Visiting is actively encouraged. Relatives interviewed stated they could visit at any time. Community entertainers are brought into the facility. The rest home resident is supported to maintain community involvement. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. Complaints information is available at the entrance and information is provided to residents and relatives at entry.  An established and up to date complaints register is also included on an access database format. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response. Specific QIs are raised from complaints. For 2015 (YTD), there have been five verbal complaints. The complaints were well documented and managed.  A complaints procedure is provided to residents within the information pack at entry. A post-admission satisfaction survey identifies if any relatives are unaware of the complaints procedure. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Code of rights leaflets are available at the front entrance of the facility. The information pack for new residents/families on entry includes information about the code of rights, complaints procedure and visiting rights. Code of rights posters are on the walls in the facility. Resident and families right to access advocacy services is identified and advocacy service leaflets are also available at the front entrances. On entry to the service, the operations manager or clinical manager discusses the information pack with the resident and their family/whānau. Discussions with the caregivers identify they are aware of the right for advocacy and how to access and provide advocacy information to residents if needed. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and ongoing assessment includes gaining details of resident’s beliefs and values. Interventions to support these are identified and evaluated. Staff can describe the procedures for maintaining confidentiality of resident information and employment agreements bind staff to retaining confidentiality of client information. The service's philosophy focuses on residents' right to respect, privacy and security is implemented in practice. There is a policy that covers abuse and neglect and staff have completed abuse and neglect training in July 2015. During the visit, staff demonstrated gaining permission prior to entering resident private areas. Interviews with family members identified that caregivers always respect residents' privacy. Resident files are held in a locked cabinet in the nurses’ station. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There are policies and procedures for the provision of culturally safe care for Māori residents. On the day of the audit, one resident identified as Maori. There is an established Māori Health plan. Cultural needs are addressed in the care plan. Family/whānau involvement is encouraged in assessment and care planning. There are current guidelines for the provision of culturally safe care for Māori residents. The service's philosophy results in each person's cultural needs being considered individually. Bi-cultural awareness training occurred as part of the annual in-service education programme in June 2015. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service philosophy focuses on residents' right to be accepted as an individual and being given the opportunity to enhance the values in their lives thereby enables residents to be individuals. This flows through into each person’s care plan and could be described by caregivers. During the admission process, the registered nurse along with the family/whānau completes the documentation. Regular reviews are evident and the involvement of family/whānau is recorded in the resident care plan. Family members interviewed feel that they are involved in decision making around the care of the resident. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. Complaints regarding any alleged harassment, coercion, discrimination or abuse of any kind by a staff member are fully investigated and may be dealt with via both the complaint management and disciplinary processes. Discussions with the operations manager and a review of complaints identified no complaints of this nature. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | CI | An implemented quality improvement programme includes performance monitoring. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.  At service level, incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written, including ongoing review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting. There are a number of quality improvement projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities. QI's are raised as a result of feedback, complaints, surveys, and discussions at handover. Once completed the QI's are logged in the six monthly statistics for health and safety/infection control/quality. There is a quality and risk management plan for 2014/2015. The plan is reviewed monthly at quality meetings to measure progress towards meeting the programme objectives.  The education programme includes a comprehensive orientation programme with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling, and restraint.  Resident and relative surveys are completed annually. Other surveys include six-week post admission survey, restraint response survey and respite survey.  Two PG family members interviewed spoke very positively about the care provided and were well informed and supported. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Families stated the resident was welcomed on entry and given time and explanation about services and procedures. 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. Family members interviewed stated that they are always informed when their family member's health status changes or of any other issues arising. There is an interpreter policy in place with information included in the admission booklet.  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. Residents and families have regular contact with the operations manager and clinical manager who have an open-door policy. Eight incident forms reviewed identified family were informed. Resident files reviewed included communication with relatives. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Dementia Care NZ Limited (DCNZ) is the parent company under which Millvale House Miramar has been run since October 2011. Millvale House provides psychogeriatric level care for up to 26 residents with 25 residents in the home on the day of audit. The service also provides rest home level care for one resident.  DCNZ operates nine aged care facilities throughout NZ providing rest home, hospital, medical, dementia and psychogeriatric level care. There is a corporate structure in place, which includes the two directors and a governance team of managers and coordinators supports them. There is a regional clinical manager North Island and a regional clinical manager South Island.  There is business plan in place for all facilities, covering the period July 2015 to June 2016.  An operations manager and a clinical manager manage Millvale House on a daily basis. The operations manager reports directly to the general manager and the clinical manager reports directly to the regional clinical manager North Island. The operations manager has been in the role for the last four years. 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 for the last year having worked as an RN for DCNZ since 2011. An organisational quality systems manager, a regional clinical manager and an education coordinator also support the operations manager and clinical manager.  The operations manager and the clinical manager have each attended at least eight hours of education in the past 12 months in relation to their respective roles. The organisation holds an annual training day for all operations managers and all clinical managers. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | During a temporary absence of the operations manager, the clinical nurse manager assumes the role with support from the DCNZ management team.  There are relevant care and support policies including relevant clinical procedures for the management of psychogeriatric and rest home level residents. At Millvale House, there is two house GPs (visit 2x weekly and as needed), physiotherapist (visits fortnightly) and a contracted dietitian. Allied health professionals are accessed on an as required basis. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation wide risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the quality meeting. The operations manager and clinical manager log and monitor all quality data. Meeting minutes are maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. QI reports are provided to the monthly quality meeting. A number of meetings includes discussion of quality data and follow through of quality improvements. Staff interviewed confirmed involvement and feedback around the quality management system.  Discussions with staff confirmed their involvement in the quality programme. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2015 is being completed. Areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. Benchmarking with other facilities occurs on data collected.  Surveys are completed including (but not limited to); relatives (welfare guardians), residents, restraint response MD services, provider survey and post admission survey. Surveys reviewed included an analysis and QIs developed where needed.  The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly.  The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There are three identified goals as part of the annual H&S plan. Progress to meeting these goals are reported to the monthly H&S meetings.  Falls prevention strategies are in place that includes assessment of risk, medication review, vitamin D, assessments with physiotherapy input, exercises/physical activities, training for staff on detection of falls risk, and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Discussions with the operations manager and clinical nurse manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.  The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required.  Eight incident forms reviewed for September identified they were fully completed and followed up appropriately by the RN.  Minutes of the monthly quality meeting, health and safety meetings, and registered nurse meetings reflected a discussion of incidents/accidents and actions taken. Internal benchmarking includes an analysis. The service analyses the trends and a comprehensive report is completed that includes outcomes and further actions required at a facility and organisational level. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Millvale House employs a total of 28 staff. Staff orientation policy and procedures includes training and support packages for operations manager, clinical manager, registered nurses, caregivers, activities staff, and cook and kitchen staff. There are job descriptions available for all positions and staff have employment contracts.  Six staff files were reviewed (clinical manager, two registered nurses, two caregivers, one diversional therapist). Job descriptions were evident in all files reviewed. Performance appraisals were up to date.  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 sighted for all registered nurses, and allied/medical staff.  All six files reviewed showed evidence of orientation to roles with competency packages completed.  The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Four caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.  Competency packages for registered nurses include (but not limited to), restraint minimisation and safe practice, first aid, ACE dementia series, delirium, syringe driver, medication, neurological conditions and leadership. Caregivers competency package includes (but not limited to), restraint minimisation and safe practice, first aid, taking vital signs, safe medication administration, ACE programme and leadership. All staff also complete safe food handling, chemical safety, safe manual handling (hoist use), bi-cultural awareness and infection control.  There is a spread sheet of all staff and records all completed orientations, competencies and education attended.  There is an in-service calendar currently being implemented for 2015. The annual training programme well exceeds eight hours annually. Additionally, all caregivers are supported to complete the aged care education certificate core and dementia standards.  There are five registered nurses, one has completed InterRAI training, one is in training and three are on the waiting list.  There are 17 caregivers, 13 have completed the required dementia standards and four are in the process of completing. The diversional therapist (in training) has completed the dementia standards.  The service implements the organisations programme called 'best friends’, which comprises four x one hour sessions for caregivers and registered nurses. The programme is part of the annual education plan and includes promoting the approach that care staff are the residents 'best friend'. The education package includes role-playing, and discussions to promote empathy, understanding dementia, communication with dementia residents and providing activities that are meaningful and resident focused. The programme is tied to the vision and values of the organisation.  Non-violent crisis intervention training is also provided for staff to enable them to safely manage residents with challenging behaviours. Intercultural Awareness programme was developed in partnership with the Office of Ethnic Affairs using their in-house Intercultural Course contextualised by the service to suit the aged care sector. The course raises staff awareness of other cultures and of how different cultures communicate. Another organisational programme implemented at Millvale House is ‘orientation for families’ and 'sharing the journey' which is designed for dementia residents families to provide education, understanding and coping with dementia progression, understanding behaviours, and responding to behaviours. Two family members interviewed confirmed that they felt well supported and appreciated the service's provision of education for them around understanding dementia. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | 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 home 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 operations manager works full time and the clinical manager works full time providing clinical administration and rostered registered nurse shifts. Caregivers on morning and afternoons work a mixture of short and long shifts. There is a designated cleaning person. Interviews with two registered nurses, four caregivers, and two family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurse’s station. Resident records are kept up to date and reflect residents' current overall health and care status. Records can be accessed appropriately by staff.  Entries are legible, dated and signed by the relevant staff member including designation.  Individual resident files demonstrate service integration. Medication charts are in a separate folder. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are pre-entry and admission procedures in place. Residents are assessed prior to entry by the psychogeriatric team and needs assessment coordinators. The clinical manager liaises closely with the assessing teams to ensure the service can meet the assessed resident needs.  The service has a well presented information booklet for residents/families at entry. It is comprehensive and designed so it can be read with ease (spaced and larger print). The service has a programme "sharing the journey" family support group to assist them with coming to terms with a resident with advanced dementia and provides education, care and support for the family. Two family (of psychogeriatric residents) stated they received sufficient information on the services provided and are appreciative of the staff support during the admission process.  Admission agreements reviewed in five files (one rest home and five psychogeriatric) aligns with the ARC and ARHSS contract. Admission agreements had been signed within a timely manner. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a discharge planning and transfer policy to guide staff in this process. Discussions with the service confirm that resident exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of residents care through the completed internal transfer form, copy of relevant progress notes, copy of medication chart and doctor’s notes. A staff member or family member (as appropriate) accompanies the resident to the hospital. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management system includes policy and procedures that follows recognised standards and guidelines for safe medicine management practice. The RN on duty checks medications on delivery against the medication charts. RNs administer medications and they have completed annual medication competencies and education.  There were no self-medicating residents. The standing orders meet legislative requirements. All medications are stored safely. The medication fridge temperature is monitored.  All 12 medication charts reviewed had photo identification and allergies noted. There were no gaps in the administration signing sheets. ‘As required’ medications had prescribed indications for use. The 12 medication charts had been reviewed by the GP three monthly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a 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 one full time cook and one part time cook (who works weekends), one full time kitchen hand to assist with the evening meal, supper and cleaning duties and one part time cook (who works weekends). All staff have attended food safety and hygiene, chemical safety, first aid and relevant in-service training. The kitchen is located within the psychogeriatric home and is locked via a combination lock so that only staff can access this area. There is a kitchenette in the dining areas where food is dished up to residents. Containers of food are transported in hot boxes to the kitchenette, where caregivers plate and serve the meals.  The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Pureed and normal diets are provided. Resident likes and dislikes are known and alternative foods are offered. Cultural and spiritual needs are met. There are adequate fluids sighted in the kitchenette fridges and supplement protein drinks are available. 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 has all goods sealed and labelled. Goods are rotated with the delivery of food items. The cook is observed wearing appropriate personal protective clothing. 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.  The main kitchen cooks all meals on site. Temperature checks are undertaken for the fridges and freezers. Food in the pantry is stored off the floor and food in the fridge is covered and dated. Kitchen service audits are undertaken regularly. Common kitchen hazards are identified. Special diets are catered for. The service also has access to a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The reason for declining service entry to residents is recorded should this occur and communicated to the resident (as appropriate)/family. The clinical manager reports that the referring agency would be advised when a resident is declined access to the service. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The information gathered at admission is used to develop care needs and supports to provide best care for the residents. RNs complete initial assessments within 24 hours of admission including risk assessment tools. Risk assessment tools are reviewed at least three monthly. InterRAI assessments have been completed for 23 out of 26 residents. The outcomes of InterRAI assessments including the risk assessments were reflected in the long-term care plans reviewed. The diversional therapist (in training) completes a comprehensive social assessment in consultation with the resident/family.  Five psychogeriatric resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The long-term care plan is developed within three weeks of admission. The care plans are comprehensive and document interventions to meet the resident’s needs. The outcomes of InterRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs. Care plans demonstrate allied health input into the residents care and well-being. InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process. Two family members confirm they are involved in the care planning process. Five psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The care being provided is consistent with the needs of residents as demonstrated in the review of the care plans and discussion with caregivers, registered nurses, activity staff and management. Families interviewed state their relatives needs are being met. When a resident’s condition changes, the RN initiates a GP or nurse specialist consultation. Families confirmed they are notified promptly of any changes to health status.  Wound assessments and evaluations have been completed for two chronic wounds. The wound nurse and GP have been involved in the wound care and management of the two wounds. Specialist wound and continence management advice is available as needed and this could be described by the clinical manager and RNs interviewed.  Continence assessments including a urinary and bowel continence assessment are completed on admission and reviewed three monthly. The company has a continence resource person.  Pain assessments are completed for all residents with identified pain and on pain relief. Abbey pain assessments are completed for all residents unable to express pain. Pain monitoring forms used to monitor the effectiveness of pain relief are kept in the medication chart folder.  The dietitian visits regularly, completes any resident reviews due, and attends to any referrals received. The dietitian maintains progress notes in the integrated resident file.  Challenging behaviour assessments are well documented with amendments made to the care plan as required. The company has a non-violent crisis intervention coordinator who supports, advises and educates staff.  There is good specialist input into the residents care in the psychogeriatric unit. The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment. The psychogeriatric community nurse visits regularly and liaises closely with the psychogeriatric team. The psychiatrist visits residents six monthly. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The diversional therapist (DT) in training has been in the role two years. She has completed a diploma in healthcare, dementia care papers and is progressing through the DT qualifications. The DT is employed full time (10.30 am– 5.30 pm) and has two caregivers who are involved in activities each day from 1.30 pm – 5.30 pm. Care staff on duty are involved in individual activities with the residents as observed on the day of audit. There are resources available to staff for activities.  The programme for the psychogeriatric residents is focused on individual and small group activities that are meaningful including household tasks, reminiscing and sensory activities such as massage and foot spas, baking, garden walks, games music and movies.  There are three volunteers involved in the programme with spiritual services, weekly pet therapy and piano playing. Recreational doll therapy has been successfully introduced. There is a visiting priest weekly. Entertainment is scheduled fortnightly. There is a van outing weekly for residents. The DT has a current first aid certificate. The service has a wheelchair van.  Activity assessments, activity plan, 24 hour MDT care plan, progress notes and attendance charts are maintained. Resident and family meetings are held.  A comprehensive social history is completed on or soon after admission and information gathered from the relative (and resident as able) is included in the activity care plan. A 24 hour MDT care plan is reviewed at least six monthly.  Caregivers are observed at various times throughout the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions. Activities were observed to be occurring in the three lounges simultaneously. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Initial care plans were evaluated by the RN within three weeks of admission in the file reviewed. Nursing care plans are reviewed three monthly by the multidisciplinary team (MDT) and evaluated at least six monthly or earlier due to health changes. The family are invited to the three monthly MDT reviews. Other health professionals are involved as appropriate, such as the physiotherapist and dietitian. Short-term care plans are reviewed as required and resolved 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. Ongoing nursing evaluations occur daily/as indicated and are included within the progress notes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the needs assessment team. Currently there are no examples where a resident’s condition has changed and required reassessment to a different level of care. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | The service has in place, management of waste and hazardous materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. These include, but are not limited to: a) sharps procedure, b) cleaning/chemicals procedures and c) exposure to blood or other body fluid contamination policy. Training is provided to the staff around safe management, as part of the annual training plan. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. The facility displays a current building warrant of fitness which expires on 16 June 2016. Fire drills are conducted six monthly and the fire service has approved the evacuation scheme. Electrical equipment has been tested and tagged. Contractors are available 24/7 for essential services. Hot water temperature are monitored weekly and are between 45 degrees Celsius (sighted). Residents were able to move freely inside and within the secure outside environments. There is a ramp to the outsides and the paths are maintained. The psychogeriatric unit previously segregated into male and female wings has now been redesigned into two mixed gender open planned homely areas both are spacious and allow for the use of mobility equipment. There are two centralised lounges. There are outside areas that include seating and shade around the facility. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of toilets and showers with access to a hand basin and paper towels. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Communal toilets and showers are well signed and identifiable. The psychogeriatric area is divided into two homes. Each home has three toilets and two showers for up to 14 residents. There are also staff and visitor amenities. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents rooms are single and of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in communal bathrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are two lounges/dining rooms within the facility, they are well proportioned and can accommodate the lounge furniture and dining tables. Activities can occur in the lounges and/or the dining area. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The service has in place policies and procedures for effective management of laundry and cleaning practices. This included (but is not limited to) collection of soiled laundry, linen processing and transporting. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. There is a sluice room for the disposal of soiled water or waste. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. There is staff on duty with a current first aid certificate. The facility has an approved fire evacuation plan and fire drills occur six monthly. Smoke alarms, sprinkler system and exit signs were in place. Emergency lighting and cooking is available in the event of a power failure. There are two civil defence kits in the facility and stored water. Call bells are evident in resident’s rooms, lounge areas and toilets/bathrooms. The facility is secured at night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection programme is reviewed annually at an organisational level. Annual goals for 2015 are in place.  The IC programme plan and IC programme description are available. There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the infection control committee at service and organisational level.  An established and implemented infection control programme is linked into the objectives of the quality and risk management plan. The IC programme includes seven objectives that include performance indicators and evaluation. There are three site-specific goals to reduce chest infections monthly by 20%, to increase educational awareness on IC issues and to ensure all staff/residents have the flu vaccine.  The IC meeting meets monthly and at an organisational level six monthly. The facility has access to professional advice within the organisation, from GPs and from an IC consultant.  Hand hygiene notices are in use around the facility. There is a staff health policy and staff infection and work restriction guidelines. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The monthly infection control committee meeting includes IC as an agenda item. The IC committee is made up of a cross section of staff from across the service. The service also has access to IC consultant, Pubic Health, GPs and local community laboratory infection control team. The IC nurse reviews support from the organisation staff trainer, and she has completed external training through CCDHB. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There is an infection control manual which includes policies and procedures appropriate to for the size and complexity of the service. There are policies and procedures that include but are not limited to a) infection control nurse responsibilities b) antimicrobial usage c) infection control including renovations and construction; d) accidental exposure to blood e) healthcare waste, f) definitions of infections g) outbreak management. Any changes or updates to the infection control policies are notified at the staff meetings |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand hygiene competency. The IC coordinator (registered nurse) has completed external training. Staff receive infection control on orientation and annual infection prevention and control education. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.  Individual infection report forms and short term care plans are completed for all resident infections. Infections are collated in a monthly register and a monthly report is completed by the infection control co-ordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with caregivers and nursing staff confirm their understanding of restraints and enablers. There were no residents using enablers on the day of audit. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | Responsibilities and accountabilities for restraint are outlined in the restraint policy and include roles and responsibilities for the restraint coordinator (RN) and approval group. A restraint approval group meets six monthly. The group includes the restraint coordinator, clinical manager, operations manager, DT, company educator and family representative. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments are undertaken by the restraint coordinator/RN in partnership with the resident and their family. Restraint assessments are based on information in the care plan, family, staff and GP consultation and during observations. The restraint assessment tool is completed for residents requiring an approved restraint for safety. There is provision for emergency restraint if required for safety of the residents, other residents/staff.  Ongoing consultation with the family and staff is evident through multidisciplinary meetings and facility meetings. There were eight residents with the use of restraint as required (four arm restraints, one bedrail and three T belts). Three restraint files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.  Restraint authorisation is in consultation/partnership with the family, restraint coordinator and GP. Internal audits are completed three monthly, ensuring all restraint processes are completed as per the restraint policy and procedures. The restraint coordinator reports that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form (sighted).  A restraint register is in place providing an auditable record of restraint use. This has been completed for all residents requiring restraints. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur six-monthly as part of the multi-disciplinary review for the resident on restraint. Families are included as part of this review. A review of three files of residents using restraints identified that evaluations were up-to-date. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Restraints are discussed and reviewed at the monthly facility restraint meetings, RN meetings, staff meetings and six-monthly restraint meetings. Meeting minutes include a review of the restraint and challenging behaviour education and training programme for staff. Staff receive orientation in restraint use on employment. The company non-violent crisis intervention coordinator provides training for staff. There is internal benchmarking. |

# 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.

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| No data to display |

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

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Services are provided at Millvale Miramar that adhere to the health and disability services standards. There are well-developed manuals for all areas of the service.  A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, infection control meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.  There is an internal audit schedule. Corrective action plans are established for areas of non-compliance.  Two family members interviewed spoke very positively about the care provided and were well informed and supported.  There are implemented competencies for all staff including caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.  The organisation has introduced resource nurses; (i) continence/skin integrity, (ii) wound nurse, (iii) falls coordinator - linked to falls project in business plan. | Benchmarking with other Dementia Care NZ facilities with psychogeriatric level care occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents, staff accidents) and clinical record audits. At service level, incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including ongoing review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting (sighted). Improvements were identified around falls, following corrective actions implemented July 2015. There are a number of quality improvement (QI) projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities. QI's are raised as a result of feedback, complaints, surveys, staff or management suggestions, ideas, and discussions at handover. Once completed the QI's are logged in the six monthly statistics for health and safety/infection control/quality. There is a quality and risk management plan for 2015. The plan is reviewed monthly at quality meetings to measure progress towards meeting the programme objectives.  The education programme includes a comprehensive orientation programme with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling, and restraint. All care staff are supported to complete first aid qualifications and the ACE programme including dementia unit standards. The annual education programme is comprehensive and includes programmes designed and implemented by the service: "best friends" is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular “Best Friends Approach to Dementia Care” (putting yourself in their shoes) training is carried out for all staff regularly and this is key to living their values and philosophy. A monthly evaluation of incident reports including ‘behaviours that challenge’ identifies good use of de-escalation techniques. Non-violent crisis intervention training and intercultural awareness training is ongoing at Millvale Miramar. In-service education sessions include input from external specialists and clinical policies and procedures are updated to reflect good practice.  DCNZ continues to provide support to the Millvale Miramar team with the introduction of a new organisational role of ‘Wellness Support Advisor’. This position provides expertise in BPSD and person centred care. Millvale House Miramar has a staff member who has shown to have good knowledge around BPSD and skills in de-escalation techniques as the onsite BPSD advisor. There is supervision for all registered nurses. Mentoring of staff by more senior members is facilitated. Families are provided with two programmes called 'sharing the journey' and ‘orientation for families’. Families interviewed spoke positively about these programmes. These provide information and support for family members in understanding dementia. Evaluation of six weekly post admission surveys identified satisfaction with the admission process and communication. Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. |

End of the report.