# Millvale House Waikanae Limited

## Introduction

This report records the results of a Surveillance 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 Waikanae Limited

**Premises audited:** Millvale House Waikanae

**Services audited:** Hospital services - Psychogeriatric services;

**Dates of audit:** Start date: 9 December 2015 End date: 9 December 2015

**Proposed changes to current services (if any):** A 15 bed dual purpose wing has been reconfigured into a secure 15 bed psychogeriatric wing increasing the total number psychogeriatric beds to 30 as of November 2015. The new wing was verified at this audit as suitable to provide psychogeriatric services.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 30

# 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** |
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|  | 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

Millvale House is part of the Dementia Care New Zealand group, which is privately owned. The service is certified to provide psychogeriatric level of care for up to 30 residents. On the day of the audit, there were 30 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents’ and staff files, observations, and interviews with relatives, general practitioner, management and staff.

The clinical manager is a registered nurse who has been in the role two years. She is supported by an operations coordinator. The regional clinical manager visits the site regularly. The team are supported by Dementia Care NZ, quality systems manager and an education co-ordinator.

Relatives commented positively on the standard of care and services provided at Millvale House.

The service has addressed the one previous certification finding around restraint monitoring and the one finding from the previous partial provisional audit around medication dates. The service has reconfigured the 15-bed dual-purpose wing into a 15-bed psychogeriatric level of care wing. The bedrooms and communal areas within the wing have been completely refurbished. The outdoor area of the reconfigured wing has been landscaped and provides a secure environment for the residents.

There were no findings at this surveillance audit. The service has maintained continuous improvement ratings around governance, quality data, and the quality management programme.

## 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. |  | Standards applicable to this service fully attained. |

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.

## Organisational management

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

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 New Zealand facilities. There is 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. Staffing rosters indicate there are suitable staff on duty to care for residents. The service has a documented and implemented training plan.

## Continuum of service delivery

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| 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. |

Assessments, care plans, interventions and evaluations are the responsibility of the registered nurses. The multidisciplinary team and families are involved in the review of the care plan. 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 psychogeriatrician as required.
The activity team provides a seven-day programme of meaningful activities that meets the recreational needs and preferences of each resident. Individual activity plans are developed in consultation with the family and resident (as appropriate).
The medication management system meets legislative requirements. Registered nurses are responsible for the administration of medications. Education and medication competencies are completed annually. 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 building has a current warrant of fitness.

## 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 thirteen residents using restraints. 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 coordinator (registered nurse) is responsible for the collation and reporting of infections. There are policies and guidelines in place for the definition and surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

## Summary of attainment

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

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| **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** | 2 | 16 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 3 | 38 | 0 | 0 | 0 | 0 | 0 |

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| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The service has a complaints policy and procedures in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Three caregivers, one registered nurse (RN) and one clinical manager interviewed were aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained with a current complaints register. There have been three complaints recorded for 2015, year to date. All are well documented including investigation, follow-up and resolution. Family members advised that they were aware of the complaints procedure and how to access forms. Complaints are discussed at the monthly quality management meetings and staff meetings.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy in place, information on which is included at the time of admission. A site-specific introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility. Family members have regular contact with the operations coordinator and clinical manager who have an open-door policy. Incident forms reviewed identified family were informed. Three 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.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | CI | Dementia Care New Zealand Limited (DCNZ) is the parent company under which Millvale House Waikanae operates. Millvale House Waikanae provides psychogeriatric level care for up to 30 residents. There were 30 residents in the home on the day of audit. All residents were under the ARHSS contract.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. There is a regional clinical manager North Island and a regional clinical manager South Island. There is a business plan 2015-2016 in place for all facilities. An operations coordinator and a clinical manager/RN manage Millvale House Waikanae on a daily basis. The operations coordinator has been in the role for three months and has previously worked for the organisation as a caregiver. The clinical manager (registered nurse) is responsible for the clinical oversight of the service. The clinical manager has been in the role since September 2013. An organisational quality systems manager, a regional clinical manager and an education coordinator also support the operations coordinator and clinical manager.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.The organisation holds an annual training day for all operations managers and all clinical managers. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | CI | 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 coordinator and clinical manager log and monitor all quality data. Meeting minutes are maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Quality improvement (QI) reports are provided 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 has been completed as per the 2015 schedule. 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. The annual survey conducted in September 2015 evidences that families/EPOA are overall very satisfied with the service. 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 newsletters. Corrective actions and quality improvements are developed following all meetings, audits, surveys, with evidence of actions completed and sign-off of all required interventions.The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with current best practice. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are in place that includes assessment of risk, medication review, vitamin D administration, physiotherapy assessments and involvement, exercises/physical activities, training for staff on falls risk and prevention, and awareness of environmental hazards. 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 coordinator and clinical manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There were two Section 31 notifications to the Ministry and DHB. Both notifications were fully investigated with corrective actions implemented and have been resolved and closed off. 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. Ten incident forms reviewed for the last week in November identified they were fully completed and followed up appropriately by the registered nurse. 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 Waikanae employs 35 staff. Staff orientation policy and procedures includes training and support packages for operations coordinator, clinical manager, registered nurses, caregivers, activities staff, cook and kitchen staff. There are job descriptions available for all positions and staff have employment contracts. Five staff files were reviewed. 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. Copies of practising certificates were sighted for all registered nurses, and allied/medical staff.  The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. There is an in-service calendar 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. All five registered nurses have completed InterRAI training. There are 17 caregivers employed. Thirteen have completed the required dementia standards and four are in the process of completing them. The diversional therapist has completed the dementia standards. Records of staff training is maintained. The service implements the organisations programme called 'best friends’, which comprises of four 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.  |
| 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. Sufficient staff are rostered on to manage the care requirements of the residents. There are three caregivers on the morning and afternoon shifts (two full shifts and one short shift) per wing. There is one caregiver on night shift each wing. The operations coordinator and the clinical manager both work full time Monday to Friday. Interviews with a registered nurse, caregivers and family members identify that staffing is adequate to meet the needs of residents.Caregivers interviewed confirmed that they are able to complete the additional cleaning and laundry duties as part of their role. There is a dedicated cleaning/laundry person for two and a half hours per day Monday to Sunday.  |
| 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. A tracking sheet with all stock medication expiry dates has been developed. All medications in stock were within the expiry dates. The previous finding has been addressed. RNs only administer medications and they have completed annual medication competencies and medication 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 eye drops and eye ointments sighted in the medication trolley were named and dated. The previous finding has been addressed. All 10 medication charts reviewed had photo identification and allergies noted. Medications signed as administered corresponded with the medication chart. The 10 medication charts had been reviewed by the GP at least three monthly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a kitchen manager/cook on duty Monday to Friday 7.00 am – 5.15 pm. Weekend cooks and a kitchen aid on duty support her each evening. A dietitian has audited and approved the four-week menu. All baking and meals are cooked on-site in the main kitchen. The kitchen is located between the two wings with serveries to each dining room. The kitchen is a secure area accessible to staff only. The kitchen manager/cook (interviewed) receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in kitchen. Special diets such as diabetic desserts, vegetarian, pureed meals and alternative choices for dislikes are accommodated. High protein drinks and foods are readily available. Finger foods and nutritious snacks (sighted) are available 24 hours. A daily log is maintained of end cooked food temperatures, fridge and freezer temperatures. Temperatures are recorded on all chilled and frozen food deliveries. All foods in the chiller, fridges and freezers are dated. Chemicals are stored safely. Cleaning schedules are maintained. Food services staff have completed food safety unit standards.  |
| 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 provided is consistent with the needs of residents as demonstrated in the review of the care plans and in discussion with caregivers, registered nurse, activity staff and management. Families interviewed state their relatives needs are being met. The RN initiates a GP or nurse specialist consultation when a residents’ condition changes. Families confirmed they are notified promptly of any changes to health status. Wound assessments and evaluations have been completed for eight minor wounds, and one grade-2 sacral pressure injury. The GP, dietitian and physiotherapist were involved in the wound care of the pressure injuries. Specialist wound and continence management advice is available as needed and the clinical manager and RN (interviewed) could describe this. 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.  Challenging behaviour assessments are well documented with amendments made to the care plan as required. The company has a non-violent crisis intervention coordinator and behaviour management specialist who supports, advises and educates staff. There is good specialist input into the residents care. The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment. The caregivers stated they have the equipment available to safely deliver care as documented in the resident care plans including hospital ultra-low beds, sensor mats, hoists and chair scales.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 activity team of three provide a total of 117 hours across the seven-day week. The diversional therapist (DT) is the assessor for the two DTs in training. The DT is employed full time (10.30 am – 5.30 pm) and the two DTs in training cover the 1.30 pm – 5.30 pm shifts and the weekend 10.30 am – 5.30 pm shifts. They all hold a current first aid certificate and attend on-site education including challenging behaviours. 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 observed was appropriate for older people with mental health conditions. Activities were observed to be occurring in the lounge of each wing simultaneously.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, gardening, walks, games, music and movies. Activity assessments, activity plan, 24 hour MDT care plan, progress notes and attendance charts are maintained. 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.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the file reviewed, initial care plans were evaluated by the RN within three weeks of admission. 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 utilised for short-term needs and reviewed as required with any ongoing problem added to the long-term care plan. Ongoing nursing evaluations occur daily/as indicated and are included within the progress notes.  |
| 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 building has a current warrant of fitness, which expires 12 June 2016. The previous 15-bed dual-purpose wing was reconfigured to a 15-bed psychogeriatric wing in November 2015. The bedrooms and communal areas in the wing (dining, lounge and seating alcoves) have been refurbished and redecorated. The previous hospital entrance now opens into a secure outdoor garden and walking area with entrances back into either wing. All external doors are alarmed after hours. There is now one main entrance into the building. There is internal secure access to both wings.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The business and project manager for Dementia Care NZ liaised with the fire engineer, in regards to the door alteration in the reconfigured secure wing and the main entrance to and from the facility. As the exit door was still only one door of many within the building, there was no need for a review of the fire evacuation plan. This door is included in our compliance schedule and routinely checked. The exit door is connected to the fire alarm and are released automatically when the fire alarm is activated. |
| Standard 3.5: SurveillanceSurveillance 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. Infection control data is collated monthly and reported at the infection control meetings. Infection control data is on display for staff. There are six monthly organisation meetings where surveillance is discussed and education occurs. The surveillance of infection data assists in evaluating compliance with infection control practices, identifying trends and corrective actions/quality initiatives. Benchmarking occurs within the organisation against other facilities.Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback /information to the service. There have been no outbreaks in the last two years.  |
| Standard 2.1.1: Restraint minimisationServices 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 the caregivers and registered nurse confirm their understanding of restraints and enablers. There were no residents using enablers on the day of audit and 13 restraints approved for use as required (one waist belt, five T belts, one bedrail and six hand-holding). |
| Standard 2.2.3: Safe Restraint UseServices 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. 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 that details frequency of monitoring, observations, cares and interventions required during each episode of restraint. Thirteen restraint-monitoring forms (one waist belt, six arm restraint, five T belt and one bedrail) were reviewed. Six monitoring forms for arm restraint evidenced intermittent use only. Seven monitoring forms evidenced monitoring had occurred at the required frequency. The previous finding around documented monitoring frequency has been addressed. |

# 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.

|  |
| --- |
| 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 1.2.1.1The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | Dementia Care NZ Ltd owns and operates Millvale House Waikanae. Millvale House Waikanae is governed by directors/proprietors who provide specialist dementia care services to residents in facilities around New Zealand. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. The vision for the organisation is 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'. The service aims to achieve the vision by promoting the uniqueness of each person, acknowledging the immense value of each person and by promoting openness, honesty and integrity. Dementia Care NZ Ltd has well established business, strategic, quality and risk organisational plans being implemented for Millvale House Waikanae. The operations manager of Millvale House Waikanae is responsible to the directors and reports on a monthly basis on a variety of issues relating to the strategic and quality plan.The proprietors have a current charter, organisational structure, and business plan as well as a current quality and risk organisational plan for 2015/2016. The operations manager and a quality and systems manager for the organisation manage the quality programme. There are documented objectives for the current financial year including (but not limited to) vision and values, quality plan, health and safety, infection control, resident occupancy, benchmarking, medication management, complaints process, human resources, restraint minimisation, continuous quality improvement, communication, education and training for staff including orientation and competencies, food safety, fire and evacuation and code of residents rights.  | Millvale House Waikanae is governed by directors/proprietors who provide specialist dementia care services to residents in facilities around New Zealand. There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. The vision for the organisation is 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'. The service aims to achieve the vision by promoting the uniqueness of each person, acknowledging the immense value of each person and by promoting openness, honesty and integrity. Philosophy of care incorporates: 1) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; 2) families/whānau become part of the community and are involved in their loved one’s care. They are encouraged to share their knowledge of their loved one to build trust and to promote honesty and openness; 3) small homely units provide residents with a stable and familiar environment. 4) Staff are acknowledged as people with skills and abilities who have the potential to be a positive impact on residents, families and their work teams. 5) Ensuring that residents can continue with their old roles if they wish, (eg, collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. 6) The philosophy of care is to promote participation in life activities, promote physical, healthy and emotional wellness. The philosophy of care is well demonstrated at Millvale House Waikanae. The service monitors performance in a number of ways and evidence of ongoing improvements identified. The operations coordinator completes monthly reports that analyses internal audits completed follow-ups required and progress to meeting quality projects, corrective action status, document/review changes and general. There is monthly incident trend analysis. Progress towards meeting the quality and risk management plan is monitored six monthly at organisational level and the entire plan reviewed and re-developed annually by the quality team. This is also reviewed and feedback provided from Millvale House Waikanae. Quality meeting minutes include review of infection control, health and safety, staff, families, restraint, education, quality audit outcomes, activities and marketing. Key performance indicators are benchmarked internally and with the other homes owned by the proprietors.Family/EPOA satisfaction surveys are completed annually and this assists to evaluate the implementation of the organisations philosophy of care at Millvale House Waikanae. The 2015 survey indicates a very high level of satisfaction. Corrective actions are identified and followed through as required.  |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI |  | The service gathers quality data that includes comprehensive templates to identify trends, actions and identification of resolution. Internal audits include quality improvement plans. The quality improvement plans include identified problem, action and ongoing evaluation of action undertaken. Audit results are collated and documented. Results are then fed back to staff at appropriate forums, for example staff, health and safety meeting. Meeting minutes reflect a culture of quality improvements and ongoing review of practice. An example of this is that a quality improvement was actioned in December 2015 around maintaining food at a palatable temperature; the service identified this from the 2015 families/EPOA survey results. While this process is not yet completed, a corrective action has been raised in this audit round, the service has identified the issue and begun addressing it through their internal audit and corrective action planning process. Corrective actions have also been developed when clinical indicators are above the benchmark. Example: Falls were above the benchmark June & July 2015. A root cause analysis was completed and individual actions implemented for those ‘at risk’ residents. Analysis of individual resident fall completed and incorporated in care plan. Evaluation identified falls rate in August was now lower than benchmark. |
| Criterion 1.2.3.7A process to measure achievement against the quality and risk management plan is implemented. | CI | A process is implemented to measure achievement against goals in the strategic business plan and quality and risk management plan. Formal review takes place six monthly. Millvale House Waikanae holds monthly quality meetings, weekly internal management meetings, monthly registered nurse meetings, home managers’ meetings and the operations manager reports monthly to the directors of Dementia Care NZ. Internal audits are completed and include the identification of any issues and corrective actions where required. Corrective actions are discussed at the monthly quality meetings and monthly staff meetings and the service ensures that all corrective actions are followed through and signed off. Incidents, accidents, hazards, complaints, infections, education, activities, marketing, quality systems and restraint are monitored through the monthly quality meetings.Monthly internal benchmarking of the service in areas, but not limited to, resident accidents and infections, staff accidents are used to measure the effectiveness of the objectives of the quality and risk management plan. Resident meetings occur monthly and an annual family focus group is held. | The service is proactive in monitoring outcomes from their quality management programme through meetings, and quality reports and through their vision and values and the impact on family through the family focus group. Reports provided to the monthly quality meeting include clinical manager monthly report, education coordinator monthly report, quality systems manager monthly report, activities team monthly report and marketing monthly report. Ongoing quality improvements are monitored through all meetings and annual goals are evaluated. A family focus group meeting is held annually (last held in February 2015) the directors, and a quarterly Advocates meeting with family was held in September 2015 with the operations coordinator, clinical manager and six family members in attendance. An action plan was completed as a result of areas family members would like to improve. A team gathering meeting with staff in October 2015 included input into reviewing previous business goals and developing goals for 2016. |

End of the report.