

Millvale House Levin 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](#).

The specifics of this audit included:

Legal entity:	Millvale House Levin Limited
Premises audited:	Millvale House Levin
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services
Dates of audit:	Start date: 18 February 2016 End date: 19 February 2016
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	21

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Millvale House Levin is part of the Dementia Care New Zealand (DCNZ) group which is privately owned. The service is certified to provide hospital and psychogeriatric level of care for up to 29 residents. On the day of the audit there were 21 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 facility is managed by a clinical manager/registered nurse who has been in the role eighteen months and with DCNZ for five years. She is supported by a non-clinical operations manager who has been in the role for three years. The North Island regional clinical manager is based at Paraparaumu. The team are supported by the owner/directors, a clinical director, quality systems manager and an education coordinator who work organisationally.

Relatives commented positively on the standard of care and services provided at Millvale House. One partial achievement from the previous certification audit remains around restraint monitoring. This audit identified an improvement required around registered nurse staffing. The service has maintained continuous improvement ratings around governance, quality and risk management systems and staff education.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The 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 complaints forms were displayed on the family notice board. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk programme includes 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 Levin 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. The service has a documented and implemented training plan.

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.



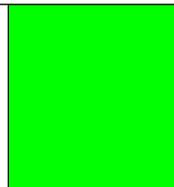
Standards applicable to this service fully attained.

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. The outcomes of the 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 general practitioner and psychogeriatric team as required. The service contract a physiotherapist and dietitian.

The activity team provides separate programmes for the hospital and psychogeriatric residents that includes 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

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

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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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 ten residents using restraints. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

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	3	12	0	2	0	0	0
Criteria	4	34	0	2	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy and procedures in place and residents and their family/whanau are provided with information on the complaints process on admission. Complaint forms are available at the entrance of the service. Staff interviewed were aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained with a current on-line complaints register. There have been ten complaints recorded for 2015. All are well documented including investigation, action plans, follow up and resolution. One complaint resulted in a Section 31 notification and was found to be unsubstantiated following full investigation and has been closed out. 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.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy in place and information on the services is provided at the time of admission. Family members have regular contact with the operations manager and clinical manager who have an open-door policy. Incident forms reviewed identified family were informed. Six family members (three hospital and three psychogeriatric level of care) interviewed stated that they are always informed when their family member's health status changes or of any other issues</p>

		<p>arising.</p> <p>The information pack and admission agreement is discussed with resident/family as part of the admission process. A site specific Introduction to Dementia unit booklet provides information for family, friends and visitors visiting the facility. Families receive a full orientation to the service. Resident meetings are open to family and are held monthly with an opportunity to feedback on all areas of the service. Six monthly family focus meetings with the directors encourages open and effective communication. The information pack contains information on how to access the family support person.</p> <p>The service has policies and procedures available for access to interpreter services and residents (and their family/whānau).</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>CI</p>	<p>Dementia Care New Zealand Limited (DCNZ) is the parent company under which Millvale House Levin operates. Millvale House Levin provides hospital and psychogeriatric level care for up to 29 residents. There were seven residents at hospital level and 14 residents at psychogeriatric level of care (including two under 65 years of age) on the day of audit. Hospital level residents were under the ARC and all psychogeriatric residents were under the ARHSS contract. There were no residents under the medical component.</p> <p>DCNZ has a corporate structure in place which includes the two owners/directors and a governance team of managers and coordinators. There is a regional clinical manager North Island and a regional clinical manager South Island. The 2014 – 2015 business plan has been reviewed by the governance team, clinical director, quality systems manager and education coordinator. There is three year strategic plan 2015-2018 in place for all facilities.</p> <p>An operations manager and a clinical manager/RN are responsible for the daily clinical and non-clinical operations of the facility. The operations manager has been in the role for three years and oversees the non-clinical services. The clinical manager (registered nurse) and has been employed by DCNZ for five years. There are senior caregivers appointed as home managers during the weekdays and weekend. The team at Millvale Levin is supported by a regional clinical manager/RN for North Island facilities who is based in Kapiti. An organisational quality systems manager, a company clinical director, education coordinator/psychiatric RN and owners/directors regularly visit the facility and provide support to the team at Millvale Levin.</p>

		<p>The vision, values and philosophy of the organisation are documented.</p> <p>The organisation holds an annual training day for all operations managers and all clinical managers. Both managers have attended at least eight hours of training relevant to their roles.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>CI</p>	<p>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, health and safety/infection control committee and facility meetings. 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. Quality data and quality improvements/initiatives are discussed at meetings and evidenced in the meeting minutes. Staff interviewed confirmed involvement and feedback around the quality management system. There is a monthly "staff bulletin" that includes quality data. The service analyses the trends and a comprehensive report is completed that includes outcomes and further actions required at a facility and organisational level.</p> <p>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 (less than 100%) identified in audit results have a corrective action plan developed and signed off as completed. Benchmarking with other facilities occurs on data collected.</p> <p>The annual survey conducted in July 2015 evidences that families/EPOA are over all 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. .</p> <p>The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with current best practice. Clinical policies are linked to the interRAI assessment tool. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly.</p> <p>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</p>

		<p>falls. The service has implemented a reduction in falls project that is linked to the business goals.</p> <p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>The service has maintained a continuous improvement rating.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Discussions with the operations manager and clinical manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is evidence of three section 31 notifications made within the last year. The relevant authorities were notified of an outbreak in December 2015.</p> <p>Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required. Nine incident forms reviewed from the month of January 2016 identified they were fully completed and followed up appropriately by the registered nurse. All incident/accident forms reviewed evidenced the family had been notified promptly of the incident by phone.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	CI	<p>Millvale House Levin employs a total of 40 staff. Staff orientation policy and procedures includes training and support packages for all staff across the services. 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 were sighted for all registered nurses (RN) and allied/medical staff.</p> <p>Five staff files were reviewed. There are job descriptions, performance appraisals and relevant recruitment documents in files reviewed.</p> <p>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.</p> <p>The 2015 education in-services have been completed as scheduled and the 2016 programme has commenced. The annual training programme well exceeds eight hours annually. Two RNs and the clinical manager are interRAI competent.</p> <p>There are 19 caregivers employed that work in the psychogeriatric unit. Seventeen have completed the required dementia standards. Two caregivers who have been</p>

		<p>employed less than 12 months have not yet completed the dementia unit standards.</p> <p>Two diversional therapists (DT) in training have completed the dementia standards. One activity person has been employed less than three months. Records of staff training are maintained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	PA Low	<p>Rosters are in place and show adequate caregivers across the hospital and psychogeriatric unit for all shifts to manage the care requirements of the residents. The DHB currently supports level 2 funding (in the psychogeriatric unit) for an hour a day.</p> <p>There is one registered nurse on duty in the facility 24/7. The service does not meet contractual requirements for RNs.</p> <p>The operations manager (non-clinical) is employed full time from Monday to Friday. The clinical manager covers three RN shifts per week and has two clinical management a days per week. The clinical manager provides on call cover. There is a DT in training from 1 – 5pm in each unit.</p> <p>Interviews with caregivers confirmed that staffing is adequate to meet the needs of residents.</p> <p>There is a dedicated cleaning/laundry person for five hours a day seven days a week.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management 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. All medications in stock were within the expiry dates. Registered nurses administer medications and have completed annual medication competencies and medication education. The service has implemented an electronic medication system. There were no self-medicating residents. There were no standing orders. The medication fridge temperature is monitored daily. All eye drops sighted in the medication trolley were dated on opening.</p> <p>All 10 medication charts reviewed on the electronic medication system were current, had photo identification and allergies noted. The 10 medication charts had been reviewed by the GP at least three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>There is a qualified cook on duty Monday to Sunday 7am—5.30pm. The cook is supported by a tea person on duty each evening. The four week menu has been</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>audited and approved by a dietitian October 2015. All baking and meals are cooked on-site in the main kitchen. Meals are served directly from the kitchen to the residents in the hospital dining room. Meals are plated and transported in a hot box to the psychogeriatric unit dining room.</p> <p>The 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 alternative choices for dislikes are accommodated. High protein drinks and foods are readily available. Finger foods and nutritious snacks (sighted) are available 24 hours in the psychogeriatric unit.</p> <p>A daily log is maintained of end cooked food temperatures, fridge and freezer temperatures. All foods are dated in the chiller, fridges and freezers. Chemicals are stored safely. Cleaning schedules are maintained.</p> <p>Food services staff have completed food safety unit standards and chemical safety.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The care being provided is consistent with the needs of residents as demonstrated in the review of the care plans and in discussion with care staff. 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.</p> <p>Wound assessments and evaluations have been completed for three minor wounds, one grade 2 pressure injury of the buttock and one chronic diabetic ulcer. The GP, dietitian and wound care specialist has been involved in the wound care management. Pressure injury assessments are completed and reviewed for all residents at risk. There were appropriate pressure injury interventions in place and documented in the care plans. Skin care and pressure injury prevention training had been held within the last 12 months. A wound nurse specialist linked to the Mid-central DHB visits the service fortnightly to assess and follow-up on wounds. The wound care specialist (interviewed) assesses equipment, dressings and provides education for RNs.</p> <p>Specialist wound and continence management advice is available as needed and this could be described by the clinical manager and RNs interviewed. Continence assessments include a urinary and bowel continence assessment are completed on admission and reviewed three monthly.</p> <p>Pain assessments are completed for all residents with identified pain. Abbey pain</p>

		<p>assessments are completed for all residents unable to express pain. Pain monitoring forms are used to monitor the effectiveness of pain relief.</p> <p>Challenging behaviour assessments are well documented with amendments made to the care plan as required. The company has a non-violent crisis intervention co-ordinator and behaviour management specialist who supports, advises and educates staff. Behaviours that challenge were well identified through the assessment process in the residents files reviewed. Twenty four hour multidisciplinary care plans describe the resident's usual signs of wellness, changes and triggers, interventions and de-escalation techniques (including activities) for the management of challenging behaviours. Behaviour charts and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours.</p> <p>There is good specialist input into the residents care. Strategies for the provisions of a low stimulus environment could be described by the care team and diversional therapist (in training).</p> <p>The caregivers stated they have the equipment available to safely deliver care as documented in the resident care plans.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employ two diversional therapists (DT) in training. The third team member has been in the role two months. Both DTs in training have completed the dementia unit standards. The activity team provide a five day week programme for the hospital residents and a seven day a week programme in the psychogeriatric unit. The team work between the hours of 1-5pm. 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.</p> <p>The hospital programme has set activities with the flexibility to add other activities as suggested by residents or as appropriate according to the resident's preference. Events and themes are celebrated. Pet therapy, entertainers and outings are included in the programme. Volunteers are involved in bible readings and a local priest visits on request. One on one time is spent with residents who do not wish to participate in the group programme.</p> <p>The programme for the psychogeriatric residents is focused on individual and small group activities that are meaningful including household tasks, reminiscing and sensory activities. The activities observed were appropriate for older people with mental health conditions. Activities were observed to be occurring in the lounge of each unit simultaneously. Activity assessments, activity plan, 24 hour MDT care plan, progress notes and attendance charts are maintained. The activity plan and</p>

		<p>care plan are reviewed at the same time three monthly.</p> <p>Resident meetings are open to families to attend.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>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 utilised for short term needs and reviewed as required with any ongoing problem added to the long term care plan. On-going nursing evaluations occur daily/as indicated and are included within the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current warrant of fitness which expires 31 October 2016.</p> <p>The outdoor area for the psychogeriatric unit has been landscaped with gardens and a shaded seating area. There is a large flat deck area and there are several safe entry/exit points within the psychogeriatric unit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer (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 included in the monthly "Staff Bulletin" on display for staff. There are six monthly organisation skype meetings for the North Island infection control officers where surveillance is discussed and education occurs. Benchmarking occurs within the organisation against other facilities.</p> <p>Internal infection control audits are completed twice yearly and assist the service in evaluating infection control needs. Staff complete annual hand hygiene audits. There is close liaison with the GP's that advise and provide feedback /information to the service. There has been one outbreak (December 2015) which was contained within one unit and appropriately managed in consultation with Public Health.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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</p>

		enablers on the day of audit.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. The hospital has an RN on duty 24/7 who covers the psychogeriatric unit. The clinical manager/RN is an additional RN two days per week. Staffing requirements on night duty meet contractual requirements.</p>	<p>Registered nurse staffing levels do not meet the requirements for a hospital and a psychogeriatric unit. There are two registered nurses on duty for two mornings a week only (clinical manager and a registered nurse). For five mornings a week there is one registered nurse on duty and for afternoon shifts there is one RN on duty to cover both the psychogeriatric and hospital units. There is one RN on duty overnight. The risk is considered to be low due to low resident numbers currently in the hospital unit. There has been ongoing communication between the provider and DHB/HealthCERT regarding the RN staffing levels in this small facility.</p>	<p>Ensure there is</p> <ol style="list-style-type: none"> 1. A registered nurse rostered on duty in the hospital between the hours of 7am and 10pm 2. A registered nurse rostered on duty in the psychogeriatric unit between the hours of 7am and 10pm 3. If the total occupancy is below 50, there is one registered nurse on duty between 10pm

				and 7am. 90 days
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful initiation;</p> <p>(e) When adequate resources are assembled to ensure safe initiation.</p>	PA Low	<p>The restraint policy requires that restraint be only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, be monitored closely and this is done daily using a monitoring form or for hand holding in the progress notes. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. Three files of psychogeriatric residents were reviewed for residents with intermittent restraint (two with t belt and one arm restraint). The review identified clear instructions for use approval process, risks and monitoring requirements on the assessment and in the care plans. Eleven of 12 restraint monitoring forms reviewed complied with the approved monitoring requirements.</p>	<p>Overall residents with a t belt approved have this approved for up to two hours at any one time. However, one resident has a t belt restraint approved for a maximum of one hour at a time. Restraint records show that this had been applied three times over the last month for a period of two hours.</p>	<p>Ensure restraints are only applied for the duration for which they have been approved</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>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.</p> <p>The vision for the organisation is: 'to create a loving, warm, and homely atmosphere where each person is supported to experience each moment richly'.</p> <p>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.</p>	<p>Philosophy of care incorporates: 1) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; 2) families/whanau 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 provides 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 hobbies, interests and participate in meaningful and purposeful activities and 6) the philosophy of care is to promote participation in life activities, promote physical, healthy and emotional wellness.</p>

			<p>This is well demonstrated at Millvale House Levin. Staff attend “best friends” training sessions and in-service on the service philosophy. Wellness support advisor coordinates sessions where families communicate their experiences to staff. Staff record their meaningful “special” resident moments in resident records and communicate this to families. Families are involved in the care planning process to ensure each resident care plan acknowledges and includes the resident’s individual and unique characteristics. The small homely units create a home-like atmosphere where staff get to know the residents and family well as “best friends”. All staff are involved in one on one activities that meet the resident’s needs and are meaningful to the resident. The company provide an independent person for staff who visits the site weekly providing support for staff wellness.</p>
<p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The service has a quality programme that is implemented in practice. Quality improvement data is analysed to identify trends and themes. This includes incidents, infections, hazards, audits and complaints. The service continues to maintain the quality programme and improve on areas of service delivery. Staff are knowledgeable about quality processes. Meeting minutes reviewed include quality, infection control, health and safety and internal management. Minutes reviewed document the discussion of all quality activities. The operations manager of Millvale House Levin is responsible to the directors and reports on a monthly basis on a variety of issues relating to the strategic and quality plan.</p>	<p>The service is proactive in identifying quality improvements (QI) on an on-going basis and monitoring these until signed out as completed.</p> <p>Quality data gathered includes comprehensive templates to identify trends, actions and identification of resolution. Residents and family are provided with quality feedback and initiatives through newsletters and meetings. The quality meeting includes a discussion of new quality improvements, and unresolved/outstanding quality improvements. Internal audits include a QI plan where the results are less than expected and corrective actions are implemented and signed off as completed. Audit results are collated and documented. Results are then fed back to staff at appropriate forums, e.g. staff, Health & Safety meeting. Meeting minutes reflect a culture of quality improvements and on-going review of practice. Monthly benchmarking analysis is completed against other hospital/psychogeriatric level homes that include outcomes. Trends are analysed and areas identified</p>

			<p>for improvement are linked to quality goals.</p> <p>The outcomes of audit results identify areas of improvement across all services audited including the environment, education, behaviour management, restraint minimisation, clinical documentation and medication management. Quality goals from data collected have been identified and included in the 2016 quality plan such as the reduction of falls, end of life care, improved continence management and review of antipsychotic medications. The outcomes of quality goals impact positively on the quality of life for the residents, improved comfort, and dignity and pain management.</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	CI	<p>A process is implemented to measure achievement against goals in the strategic business plan, a yearly business plan and quality and risk management plan. Millvale Levin 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. Quality meeting minutes include review of infection control, health and safety, restraint, education, quality audit outcomes and activities. Key performance indicators are benchmarked internally and with the other homes owned by the proprietors. The service identified (through benchmarking and accident/incident review) that the number of falls per month in the psychogeriatric unit were above the key performance indicator. The service included a falls reduction goal into the business plan for 2015 – 2016.</p>	<p>Falls rates were identified to be higher than expected for residents in the psychogeriatric unit leading up to the month of October 2015. In October 2015 there were 15 falls reported that occurred in the psychogeriatric unit (PG) prior to commencement of the falls project.</p> <p>The organisation developed an action plan for each facility to implement where falls were higher than expected. A falls coordinator has been nominated for each facility. The falls coordinator/RN (interviewed) was appointed in August 2015 and has a job description which includes; reviewing of policies and procedures around falls prevention, ensuring staff complete and understand the falls competency pack, reviewing of all accidents/incidents and analysing the cause and providing staff education around falls prevention and interventions (December 2015). The falls coordinator attended falls prevention in November 2015 at the DHB and has completed on-line training linked to ACC courses. All resident care plans were reviewed to ensure individual characteristics, triggers and interventions around falls prevention and management were documented in the care plans. Staff interviewed were able to describe fall prevention</p>

			<p>strategies. A whiteboard map has been set up in the psychogeriatric nurses station and all falls are mapped as to the location and severity of the fall. This map has raised staff awareness and the requirement to continuously monitor the residents at risk of falls. Increased supervision of residents occurs.</p> <p>Falls rates for psychogeriatric residents have reduced from 15 falls in October 2015, to six falls in December 2015, to three falls in January 2016, and three falls in February 2016. The project is continuing and will be evaluated further in July 2016</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>Discussion with staff confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is on-site education and staff have an opportunity to attend external an in-service calendar being completed for 2015.</p> <p>An education coordinator (registered psychiatric nurse) is employed by DCNZ to oversee the organisation's education programme for all homes and is available to facilitate sessions. The education coordinator develops the annual education plan in conjunction with the operations manager. There are essential/compulsory attendance sessions. Other topics are added to the plan as required following feedback from audits, complaints, incidents/accidents, infection, health and safety issues and quality improvement initiatives.</p>	<p>1. The education plan also includes training that is specific to dementia care. The organisation has developed a programme called 'best friends', which comprises four one-hour sessions for all staff.</p> <p>The programme is part of the annual education plan and includes promoting the approach that care staff are the residents 'best friend'. The programme is linked to the vision and values of the organisation. The training has further extended with the introduction of 'come into my world' training. 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. Staff are supported to attend "waking in another's shoes". Staff are trained in BPSD (behavioural and psychological symptoms of dementia) and NVCi (non-violent crisis intervention). Staff present case studies at BPSD in-services for discussion and reflection on practice.</p> <p>The Best Friends Approach' course focuses on how best friends communicate and how activities can be used to achieve well-being. Staff who have attended the course state they feel more confident around residents and now have a way now to help them and</p>

			<p>make them feel good.</p> <p>2. Another organisational programme implemented at Millvale House Levin is 'orientation for families' and 'sharing the journey'.</p> <p>This is designed for dementia resident's families to provide education, understanding and coping with dementia progression, understanding behaviours, and responding to behaviours. The training was completed in January 2016.</p> <p>Family members interviewed confirmed that they felt well supported and appreciated the service's provision of education for them around understanding dementia.</p>
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End of the report.