

Millvale House Levin Limited

Current Status: 17 December 2013

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

General overview

Millvale Levin provides psychogeriatric and hospital (geriatric and medical) level care for up to 29 residents. On the day of audit, there were 16 residents in the psychogeriatric unit and 13 residents in the hospital unit.

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings. A number of education initiatives are implemented at Millvale Levin including specialist dementia training for staff and families.

An experienced aged care operations manager manages the service. A clinical manager (currently the regional clinical manager), a stable staff and the management team at Dementia Care NZ support her.

There is an improvement required by the service around restraint use.

The service is commended for achieving six continued improvement ratings relating to governance, quality systems, family information and support, quality initiatives, and implementation of a comprehensive education programme.

Audit Summary as at 17 December 2013

Standards have been assessed and summarised below:

Key

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

Indicator	Description	Definition
	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

Consumer Rights as at 17 December 2013

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Organisational Management as at 17 December 2013

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.
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Continuum of Service Delivery as at 17 December 2013

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Safe and Appropriate Environment as at 17 December 2013

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Restraint Minimisation and Safe Practice as at 17 December 2013

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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Infection Prevention and Control as at 17 December 2013

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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Audit Results as at 17 December 2013

Consumer Rights

Millvale Levin strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (The Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. 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. Complaints processes are implemented and complaints and concerns are actively managed and well documented. A complaints register is maintained.

Organisational Management

Dementia Care NZ Ltd is the proprietors/directors of Millvale Levin. The operations manager of Millvale Levin reports to the directors on a monthly basis against the quality and risk management plan and also the vision and values, which are embedded into practice. The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and other staff meetings. The service is active in analysing data and comprehensive reports, trends and action plans are completed. Corrective actions are identified and implemented and show follow up and review. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status.

Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. Friends and family satisfaction surveys are completed and regular resident/relative meetings are held.

There are comprehensive policies/procedures to provide hospital and psychogeriatric specific care. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight

hours annually and covers relevant aspects of care and support. The training programme for staff also includes specific training based around the services, “Best Friends Approach to Dementia Care”. This is carried out for all staff regularly and is key to living their values and philosophy.

Families are provided with two programmes called 'sharing the journey' and 'orientation for families'. These provide information and support for family members in understanding dementia. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of Service Delivery

There are pre-entry and admission procedures in place. The service is pro-active in the community and meets with groups such as Alzheimer’s Society. There is a well-presented information booklet for residents/families/whanau at entry that includes information on the service philosophy, services provided (hospital and psychogeriatric level) and practices particular to the secure unit. Care plans are developed by registered nurses and are reviewed six monthly by the multidisciplinary team. Families are involved in the development and review of the care plan. A multi-disciplinary nursing, activities and GP resident review occurs three monthly. The service has strong vision that is reflected in a multidisciplinary team approach that assists with support and values. All assessments are linked into the comprehensive care plan. There is at least a three monthly resident review by the medical practitioner, geriatrician and psychogeriatrician as required.

The activity team develop a programme to meet the recreational needs and preferences of each consumer group. There is a planned seven day a week programme in the psychogeriatric unit. Individual activity plans are developed in consultation with resident/family.

The medication management system includes medication policy and procedures and there is on-going education and training of staff in relation to medicine management. All medications charts have current identification photos and special instructions for the administration/crushing of medications. There is a reduction of psychotropic medication programme in place. The GP reviews the residents’ medication at least three monthly.

All cooking and baking is done on site. Nutritious snacks are available over a 24 hour period. The service has access to a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files. The dietitian reviews the menu.

Safe and Appropriate Environment

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness.

Millvale house provides hospital and psychogeriatric care delivered in separate “homes” within the building. Their philosophy of the 'small homes' mean that the environment feels more normalised, and residents orientate to their environment more easily. Each home is well maintained with easy access to the secure gardens and paths. Residents are able to move freely inside and within their separate environments.

There have been extensions to the outdoor areas including decks. Further landscaping is to be completed in the near future.

Each small home has their own dining/lounge areas. Residents/visitors are able to access other areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. Communal service areas are separate and activities can occur in the lounges and/or the dining area. The service has in place policies and procedures for effective management of laundry and cleaning practices.

General living areas and resident rooms are appropriately heated and ventilated.

The service has implemented policies and procedures for civil defence and other emergencies. There is staff on duty with a current first aid certificate at all times. Fire drills are conducted six monthly and the fire service has approved the evacuation scheme.

Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice policy and procedure applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint training is provided at orientation and is completed as part of the services annual training schedule. This includes restraint a self-directed learning and competency for restraint minimisation. Individual restraint interventions are evaluated monthly and documented in the care plan and on the restraint register. There are six residents on the register assessed as requiring intermittent restraint. The register shows a monthly review by the restraint coordinator and the register is updated each month. There is a robust restraint approval group and process in place that meet six monthly. Restraint approval group also includes a consumer representative and the service is focused on minimising restraint. There is an improvement required around restraint use.

Infection Prevention and Control

The infection control management systems are well documented and implemented to minimize the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality and risk management plan. There is a comprehensive orientation and education programme for all staff. Infection rates are monitored and benchmarked with other facilities within the organisation. Benchmarking also occurs against other similar homes and the results are used to identify any shortfalls in care services and infection control.

HealthCERT Aged Residential Care Audit Report (version 3.91)

Introduction

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under the Health and Disability Services (Safety) Act 2001 for submission to the Ministry of Health.

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

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

Audit Report

Legal entity name:	Millvale House Levin Limited
Certificate name:	Millvale House Levin Limited
Designated Auditing Agency:	Health and Disability Auditing New Zealand Limited
Types of audit:	Certification Audit
Premises audited:	Millvale House Levin
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services
Dates of audit:	Start date: 17 December 2013 End date: 18 December 2013
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	29

Audit Team

Lead Auditor	XXXXX	Hours on site	12	Hours off site	6
Other Auditors	XXXXX	Total hours on site	12	Total hours off site	6
Technical Experts		Total hours on site		Total hours off site	
Consumer Auditors		Total hours on site		Total hours off site	
Peer Reviewer	XXXXX			Hours	2

Sample Totals

Total audit hours on site	24	Total audit hours off site	14	Total audit hours	38
Number of residents interviewed	4	Number of staff interviewed	11	Number of managers interviewed	4
Number of residents' records reviewed	6	Number of staff records reviewed	6	Total number of managers (headcount)	4
Number of medication records reviewed	12	Total number of staff (headcount)	34	Number of relatives interviewed	7
Number of residents' records reviewed using tracer methodology	2			Number of GPs interviewed	1

Declaration

I, XXXXX, Director of Christchurch hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of the Designated Auditing Agency named on page one of this report (the DAA), an auditing agency designated under section 32 of the Act.

I confirm that:

a)	I am a delegated authority of the DAA	Yes
b)	the DAA has in place effective arrangements to avoid or manage any conflicts of interest that may arise	Yes
c)	the DAA has developed the audit summary in this audit report in consultation with the provider	Yes
d)	this audit report has been approved by the lead auditor named above	Yes
e)	the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook	Yes
f)	if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider	Not Applicable
g)	the DAA has provided all the information that is relevant to the audit	Yes
h)	the DAA has finished editing the document.	Yes

Dated Tuesday, 28 January 2014

Executive Summary of Audit

General Overview

Millvale Levin provides psychogeriatric and hospital (geriatric and medical) level care for up to 29 residents. On the day of audit, there were 16 residents in the psychogeriatric unit and 13 residents in the hospital unit.

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings. A number of education initiatives are implemented at Millvale Levin including specialist dementia training for staff and families.

An experienced aged care operations manager manages the service. A clinical manager (currently the regional clinical manager), a stable staff and the management team at Dementia Care NZ support her.

There is an improvement required by the service around restraint use.

The service is commended for achieving six continued improvement ratings relating to governance, quality systems, family information and support, quality initiatives, and implementation of a comprehensive education programme.

Outcome 1.1: Consumer Rights

Millvale Levin strives to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (The Code). Information about the code of rights and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. The philosophy of the service includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. 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. Complaints processes are implemented and complaints and concerns are actively managed and well documented. A complaints register is maintained.

Outcome 1.2: Organisational Management

Dementia Care NZ Ltd is the proprietors/directors of Millvale Levin. The operations manager of Millvale Levin reports to the directors on a monthly basis against the quality and risk management plan and also the vision and values, which are embedded into practice. The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and other staff meetings. The service is active in analysing data and comprehensive reports, trends and action plans are completed. Corrective actions are identified and implemented and show follow up and review. Health and safety policies, systems and processes are implemented to manage risk. Discussions with families identified that they are fully informed of changes in health status.

Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. Friends and family satisfaction surveys are completed and regular resident/relative meetings are held.

There are comprehensive policies/procedures to provide hospital and psychogeriatric specific care. There is a comprehensive orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually and covers

relevant aspects of care and support. The training programme for staff also includes specific training based around the services, “Best Friends Approach to Dementia Care”. This is carried out for all staff regularly and is key to living their values and philosophy. Families are provided with two programmes called 'sharing the journey' and 'orientation for families'. These provide information and support for family members in understanding dementia. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

Outcome 1.3: Continuum of Service Delivery

There are pre-entry and admission procedures in place. The service is pro-active in the community and meets with groups such as Alzheimer’s Society. There is a well-presented information booklet for residents/families/whanau at entry that includes information on the service philosophy, services provided (hospital and psychogeriatric level) and practices particular to the secure unit. Care plans are developed by registered nurses and are reviewed six monthly by the multidisciplinary team. Families are involved in the development and review of the care plan. A multi-disciplinary nursing, activities and GP resident review occurs three monthly. The service has strong vision that is reflected in a multidisciplinary team approach that assists with support and values. All assessments are linked into the comprehensive care plan. There is at least a three monthly resident review by the medical practitioner, geriatrician and psychogeriatrician as required.

The activity team develop a programme to meet the recreational needs and references of each consumer group. There is a planned seven day a week programme in the psychogeriatric unit. Individual activity plans are developed in consultation with resident/family.

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All cooking and baking is done on site. Nutritious snacks are available over a 24 hour period. The service has access to a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files. The dietitian reviews the menu.

Outcome 1.4: Safe and Appropriate Environment

The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. There is a current building warrant of fitness.

Millvale house provides hospital and psychogeriatric care delivered in separate “homes” within the building. Their philosophy of the 'small homes' mean that the environment feels more normalised, and residents orientate to their environment more easily. Each home is well maintained with easy access to the secure gardens and paths. Residents are able to move freely inside and within their separate environments.

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The service has in place policies and procedures for effective management of laundry and cleaning practices.

General living areas and resident rooms are appropriately heated and ventilated

The service has implemented policies and procedures for civil defence and other emergencies. There is staff on duty with a current first aid certificate at all times. Fire drills are conducted six monthly and the fire service has approved the evacuation scheme.

Outcome 2: Restraint Minimisation and Safe Practice

There is a restraint minimisation and safe practice policy and procedure applicable to the type and size of the service. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint training is provided at orientation and is completed as part of the services annual training schedule. This includes restraint a self-directed learning and competency for restraint minimisation. Individual restraint interventions are evaluated monthly and documented in the care plan and on the restraint register. There are six residents on the register assessed as requiring intermittent restraint. The register shows a monthly review by the restraint coordinator and the register is updated each month. There is a robust restraint approval group and process in place that meet six monthly. Restraint approval group also includes a consumer representative and the service is focused on minimising restraint. There is an improvement required around restraint use.

Outcome 3: Infection Prevention and Control

The infection control management systems are well documented and implemented to minimize the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality and risk management plan. There is a comprehensive orientation and education programme for all staff. Infection rates are monitored and benchmarked with other facilities within the organisation. Benchmarking also occurs against other similar homes and the results are used to identify any shortfalls in care services and infection control.

Summary of Attainment

	CI	FA	PA Negligible	PA Low	PA Moderate	PA High	PA Critical
Standards	5	44	0	1	0	0	0
Criteria	6	94	0	1	0	0	0

	UA Negligible	UA Low	UA Moderate	UA High	UA Critical	Not Applicable	Pending	Not Audited
Standards	0	0	0	0	0	0	0	0
Criteria	0	0	0	0	0	0	0	0

Corrective Action Requests (CAR) Report

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
HDS(RMSP)S.2008	Standard 2.2.3: Safe Restraint Use	Services use restraint safely	PA Low			
HDS(RMSP)S.2008	Criterion 2.2.3.2	Approved restraint is only	PA Low	Overall residents with a t	Ensure restraints are only	90

Code	Name	Description	Attainment	Finding	Corrective Action	Timeframe (Days)
		<p>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>		<p>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 30 minutes at a time. Restraint records show that this had been applied once for a period of two hours.</p>	<p>applied for the duration for which they have been approved.</p>	

Continuous Improvement (CI) Report

Code	Name	Description	Attainment	Finding
HDS(C)S.2008	Standard 1.1.8: Good Practice	Consumers receive services of an appropriate standard.	CI	
HDS(C)S.2008	Criterion 1.1.8.1	The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	<p>Benchmarking with other Dementia Care NZ facilities with psychogeriatric and hospital level care occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents, staff accidents) and clinical record audits. At service level, incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including on-going review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ</p>

Code	Name	Description	Attainment	Finding
				<p>monthly meeting (sighted). There are a number of quality improvement (QI) projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities. QI's are raised as a result of feedback, complaints, surveys, staff or management suggestions, ideas, and discussions at handover. Once completed the QI's are logged in the six monthly statistics for health and safety/infection control/quality. There is a quality and risk management plan for 2013 - 2014. The plan is reviewed monthly at quality meetings to measure progress towards meeting the programme objectives. The education programme includes a comprehensive orientation programme with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling, and restraint. All care staff are supported to complete first aid qualifications and the ACE programme including dementia unit standards. The annual education programme is comprehensive and includes programmes designed and implemented by the service: "best friends" is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular "Best Friends Approach to Dementia Care" (putting yourself in their shoes) training is carried out for all staff regularly and this is key to living their values and philosophy. At an organisational level, there is a diversional therapy coordinator to provide support to the diversional therapy team and provide diversional therapy services to residents as required. This person is based at Levin two days per week. There is a regional clinical manager (who is currently acting as the clinical manager at Millvale Levin until this role is filled) to lead and provide guidance to the clinical managers. All clinical managers meet annually to discuss clinical issues or policy changes. There is supervision for all registered nurses. Mentoring of staff by more senior members is facilitated. Non-violent crisis intervention training is on-going at Millvale Levin and intercultural awareness training has commenced. In-service education sessions include input from external specialists and clinical policies and procedures are updated to reflect good practice. Families are provided with two programmes called 'sharing the journey' and 'orientation for families'. These provide information and support for family members in understanding dementia. Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education</p>

Code	Name	Description	Attainment	Finding
				component. Millvale Waikanae is divided into two small homes. The small homes (one for the hospital and one for the psychogeriatric unit) mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel.
HDS(C)S.2008	Standard 1.1.12: Links With Family/Whānau And Other Community Resources	Consumers are able to maintain links with their family/whānau and their community.	CI	
HDS(C)S.2008	Criterion 1.1.12.1	Consumers have access to visitors of their choice.	CI	The service, as part of its commitment to holistic care has implemented a series of education sessions for families and friends, this ensures that families are well informed and are part of, and informed about, their family member's care and condition. There an orientation for families course that is a voluntary for new families of residents to assist them with the transition into care. The orientation informs the family about dementia care provided at Millvale Levin. This includes a) dementia as a journey for both the resident and the family, b) provision of information to families, c) advice on communication, and d) provide a family support network. This course is followed by the 'Sharing the Journey' course; a short course for families of people with dementia based on the service's 'Best Friends Approach to Dementia Care'. The premise of the 'best friends' approach is that the service provides care and support that one could expect of a best friend. The course aims to enable family members to understand the dementia journey, and effective ways of both communicating with and managing their family member in care. Families interviewed (seven) were complimentary about the information received and the courses. Additionally the service contracts a family support person who can provide confidential and support to family members. Information about how to contact this person is included in welcome information and displayed at the facility. The seven family members interviewed are aware of this service.
HDS(C)S.2008	Standard 1.2.1: Governance	The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	CI	
HDS(C)S.2008	Criterion 1.2.1.1	The purpose, values, scope,	CI	Millvale Levin is governed by directors/proprietors who provide

Code	Name	Description	Attainment	Finding
		<p>direction, and goals of the organisation are clearly identified and regularly reviewed.</p>		<p>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: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and 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; c) small homely units provides residents with a stable and familiar environment; d) 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; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. The philosophy care is to promote participation in life activities, promote physical and emotional wellness. This is well demonstrated at Millvale Levin. The service monitors performance in a number of ways and evidence of on-going improvements identified. The operations manager completes monthly reports that analysis internal audits completed, follow ups required, progress to meeting quality projects, corrective action status, document/review changes and general. Monthly incident trend analysis occurs and corrective action implemented as a result. Progress towards meeting the quality and risk management plan is monitored quarterly at organisational level and the entire plan reviewed and re-developed annually by the quality team. Meeting minutes for quality committee, health and safety committee and infection control committee are comprehensive and include review of the organisational and local objectives against performance measures. 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. Friends and family satisfaction surveys are</p>

Code	Name	Description	Attainment	Finding
				completed annually and the 2013 survey indicates a very high level of satisfaction. Actions are identified and followed through as required because of the survey.
HDS(C)S.2008	Standard 1.2.3: Quality And Risk Management Systems	The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	CI	
HDS(C)S.2008	Criterion 1.2.3.6	Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	<p>Quality data gathered 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 on-going evaluation of action undertaken. Audit results are collated and document. Results are then fed back to staff at appropriate forums, e.g. staff, health and safety meeting. Meeting minutes reflect a culture of quality improvements and on-going review of practice. An example of this is an internal audit conducted in September 2013 the service identified that not all PRN medications charted had a documented indication for use. A quality improvement plan was implemented and discussion held with the doctor around this (confirmed at interview with the doctor). The plan developed included that as the GP reviews medication files he will ensure that PRN medications are charted correctly. While this process is not yet completed and a corrective action has been raised in this audit around PRN medication charting the service has identified the issue and begun addressing it through their internal audit and corrective action planning process. Monthly benchmarking analysis is completed that includes outcomes. Resident and family are provided with quality feedback and initiatives through newsletters and meetings. Internal management meetings include a quality focus for the week. The quality meeting includes a discussion of new quality improvements, unresolved/outstanding quality improvements. The service is proactive in identifying quality improvements on an on-going basis and monitoring these until signed out as completed. In June 2013, the service identified that they had 16.67 falls incidents per 1000 bed days. This was lower than the reported falls in May 2013 but slightly higher than the 2012 average of 15.26. This falls rate was also the highest compared to other similar units in the organisation. The service identified residents at high risk of falling, reassessed them, and</p>

Code	Name	Description	Attainment	Finding
				implemented individual measures resulting in a lowered rate of falls for July 2013. Millvale Levin also identified that in June 2013 16.67 resident behaviour incidents occurred per 1000 bed days and while this was lower than the previous month it was higher than the average for 2012 (12.18). The rate was also higher than three of the four facilities benchmarked against. As a result monitoring was increased for residents who exhibit on going BPSD episodes than others and staff were encouraged to employ the services 'knack' approach and were reminded about triggers and the need for early intervention. Behaviour incidents have trended downwards since this time.
HDS(C)S.2008	Criterion 1.2.3.7	A process to measure achievement against the quality and risk management plan is implemented.	CI	The service is proactive in monitoring outcomes from their quality management programme through meetings, and quality reports 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/RN monthly report, education co-ordinator monthly report, quality and systems manager monthly report, activities team monthly report, marketing monthly report, and home managers' report. On-going quality improvements are monitored through all meetings and annual goals are evaluated. The family focus group meeting is held annually (last Oct 12) with the two directors and five participants. An action plan was completed as a result of areas family members would like to improve. Interview with a relative that was involved in that meeting spoke positively about the openness of the directors to make improvements. The October 2013 meeting has not yet occurred and an organisation wide quality improvement plan has been developed around this with the meeting scheduled to occur in February 2013. Team gathering meetings with staff throughout 2013 included input into reviewing previous business goals and developing goals for 2013- 2014. Six-week post admission surveys provide early feedback to the service friends and family satisfaction surveys are conducted annually.
HDS(C)S.2008	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.	CI	
HDS(C)S.2008	Criterion 1.2.7.5	A system to identify, plan, facilitate, and record ongoing	CI	A number of education initiatives are implemented at Millvale Levin. The annual education plan is comprehensive and covers

Code	Name	Description	Attainment	Finding
		<p>education for service providers to provide safe and effective services to consumers.</p>		<p>both compulsory and additional topics. Topics are included in the plan in response to and following feedback from audits (i.e.: fire competency re-written to include more relevant questions), complaints, incidents/accidents, infection, meeting minutes, health and safety issues and quality improvement initiatives. The organisation has developed a programme called 'best friends', which comprises four x one-hour sessions for all staff. 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. This year the training has further extended with the introduction of 'come into my world' training, which is across three sessions. The 'Best Friends Approach' was developed in the USA. .</p> <p>Dementia Care New Zealand have adapted the course and contextualised it to NZ culture, but the essence remains: if staff treat the people we are caring for as they would a best friend, then the person will receive the best of care. The course examines the experience of dementia from the perspective of the person with dementia and the ageing process. It looks at how to develop empathy by using interactive tools. They also explore the qualities of a best friend, the importance of knowing a person's life story and some communication role-plays. Finally the course focuses on how best friends communicate and how activities can be used to achieve well-being.</p> <p>Feedback from staff who have attended includes: "I've got a way now to help them and make them feel good," "Good to remember that this is their home and the staff are visitors to their home", "I am more confident about being around residents" and "This course has made me look forward to having 'magic moments' with the residents."</p> <p>Dementia Care NZ developed 'Come Into My World' as an extension of the Best Friends Approach and much of this course based on validation therapy. Some of the techniques and approaches explored are reminiscence, using music to remember, rephrasing what a person with dementia has said to us, mirroring behaviour and communication. The course is interactive with lots of role-plays around how people communicate and attempt to validate and accept the emotions of the person with dementia. The philosophy includes that our emotional needs remain with us</p>

Code	Name	Description	Attainment	Finding
				<p>from the cradle to the grave and to be accepted by others is as valuable as other care we receive.</p> <p>Feedback from staff who have attended the training includes: "Interesting to learn about Malignant Social Psychology and role-plays to reinforce empathy," Great new techniques to help me interact with the residents" and "A great insight into the resident's world view."</p>

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

Outcome 1.1: Consumer Rights

Consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

Standard 1.1.1: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.1)

Consumers receive services in accordance with consumer rights legislation.

ARC D1.1c; D3.1a ARHSS D1.1c; D3.1a

Attainment and Risk: FA

Evidence:

There is a code of rights policy and procedures in place. The code of health and disability rights is incorporated into care. Discussions with two caregivers (one from the psychogeriatric unit and one from the hospital) and one enrolled nurse (from the psychogeriatric unit) identified their familiarity with the code of rights. A review of care plans, meetings (monthly - quality, home managers, registered nurses, and internal management meetings) and discussion with seven family members (four hospitals and three psychogeriatric) and four residents (from the hospital) confirms that the service functions in a way that complies with the code of rights. Observation during the audit confirmed this in practice. Training was last provided on the code of rights and advocacy in September 2013. Code of rights is also included in the orientation training session and package for new staff.

Criterion 1.1.1.1 (HDS(C)S.2008:1.1.1.1)

Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.2: Consumer Rights During Service Delivery (HDS(C)S.2008:1.1.2)

Consumers are informed of their rights.

ARC D6.1; D6.2; D16.1b.iii ARHSS D6.1; D6.2; D16.1b.iii

Attainment and Risk: FA

Evidence:

The service provides information to residents, families, next of kin and/or EPOA. If necessary, staff will read and explain information to residents, for example, informed consent and code of rights. On entry to the service, the clinical manager or registered nurse discusses the information pack with the resident and their family/whānau. This includes the code of rights, complaints and advocacy information. Discussions with seven family members (four hospital and three psychogeriatric) and four residents (from the hospital) identified they are well informed about the code of rights. The service provides an open-door policy for concerns or complaints. There is an orientation for families course is provided on admission; this is voluntary for new families of residents to assist them with the transition into care. The orientation informs the family about dementia care provided at Millvale Levin. This includes a) dementia as a journey for both the resident and the family, b) provision of information to families, c) advice on communication, d) provide a family support network and e) includes resident rights. D6, 2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, COR pamphlet, advocacy and H&D Commission. Resident/family right to access advocacy and services is identified and advocacy service leaflets are available at the entrance. The information identifies whom the family can contact to access advocacy services. Information provided prior to entry provides them and their family/whānau with advocacy information. This includes details of the national and local advocacy services. Discussions with two caregivers (one from the psychogeriatric unit and one from the hospital) and one enrolled nurse (from the psychogeriatric unit) identified they are aware of the right for advocacy and how to access and provide advocacy information to residents if needed. ARHSS D16.1bii. The families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.

Criterion 1.1.2.3 (HDS(C)S.2008:1.1.2.3)

Opportunities are provided for explanations, discussion, and clarification about the Code with the consumer, family/whānau of choice where appropriate and/or their legal representative during contact with the service.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.1.2.4 (HDS(C)S.2008:1.1.2.4)

Information about the Nationwide Health and Disability Advocacy Service is clearly displayed and easily accessible and should be brought to the attention of consumers.

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

Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect (HDS(C)S.2008:1.1.3)

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

ARC D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1a; D14.4; E4.1a ARHSS D3.1b; D3.1d; D3.1f; D3.1i; D3.1j; D4.1b; D14.4

Attainment and Risk: FA
Evidence: <p>The service has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Staff can describe the procedures for maintaining confidentiality of resident information and employment agreements bind staff to retaining confidentiality of client information. Discussions with seven family members (four hospitals and three psychogeriatric) and four residents (from the hospital) identified that personal belongings are not used as communal property. During the visit, staff demonstrated gaining permission prior to entering resident private areas. Interviews with family members and residents identified that caregivers always respect residents' privacy. Resident files are held in locked nurses' offices.</p> <p>D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality</p> <p>D14.4 There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.</p> <p>Initial and on-going assessment includes gaining details of people's beliefs and values. Interventions to support these are identified and evaluated. The service contacts family prior to resident reviews and multi-disciplinary meetings inviting them to attend and discuss any concerns. All seven family members (four hospital and three psychogeriatric) and four residents (from the hospital) interviewed confirmed that the service is respectful and responsive to the resident's needs, values and beliefs. Single rooms are provided. There is an abuse and neglect policy that includes definitions and examples of abuse. Staff could describe definitions. Discussions with three registered nurses, the clinical manager, two caregivers (one from the psychogeriatric unit and one from the hospital) and one enrolled nurse (from the psychogeriatric unit) identify that there is a strong culture of reporting. Seven family members (four hospital and three psychogeriatric) and four residents (from the hospital) interviewed said that the care provided is very good. Abuse and neglect training was last delivered in August 2013 by Age Concern. In 2013, a complaint was received about possible abuse. The incident was</p>

investigated and the staff member was dismissed.

ARHSS D4.1b Three psychogeriatric resident files reviewed identified that cultural and /or spiritual values, individual preferences are identified.

Criterion 1.1.3.1 (HDS(C)S.2008:1.1.3.1)

The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.

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

Criterion 1.1.3.2 (HDS(C)S.2008:1.1.3.2)

Consumers receive services that are responsive to the needs, values, and beliefs of the cultural, religious, social, and/or ethnic group with which each consumer identifies.

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

Criterion 1.1.3.6 (HDS(C)S.2008:1.1.3.6)

Services are provided in a manner that maximises each consumer's independence and reflects the wishes of the consumer.

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

Criterion 1.1.3.7 (HDS(C)S.2008:1.1.3.7)

Consumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect.

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

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

Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.

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

Attainment and Risk: FA
Evidence: The service gathers appropriate spiritual, religious and cultural information that is relevant and sufficient to support an appropriate response to the needs of residents. There are five Maori residents but none identifies any specific cultural needs or affiliation (confirmed in family interviews). Planning is done in conjunction with the

resident/family. The service's philosophy of care results in each person's cultural needs being considered individually. External specialist advice is sought as necessary. There are current guidelines for the provision of culturally safe care for Māori residents. Discussions with three registered nurses, the clinical manager, the operations manager, two caregivers (one from the psychogeriatric unit and one from the hospital) and one enrolled nurse (from the psychogeriatric unit) indicate that they have an awareness of the need to respond appropriately to the cultural values and beliefs of Māori. Individual cultural values are identified and documented through the assessment and admission processes and staff make every effort to assist residents to practice their cultural values. Special events and occasions including Matariki are celebrated at Millvale Levin.

Family/whanau involvement is actively encouraged through all stages of service delivery. Whanau are invited to attend residents' reviews. Links are established with disability and other community representative groups as directed/requested by the resident/family/whanau.

A3.2 There is a Maori health plan includes a description of how they will achieve the requirements set out in A3.1 (a) to (e)

D20.1i The service has established a local contact who is Māori and is available for advice as required.

Criterion 1.1.4.2 (HDS(C)S.2008:1.1.4.2)

Māori consumers have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated.

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

Criterion 1.1.4.3 (HDS(C)S.2008:1.1.4.3)

The organisation plans to ensure Māori receive services commensurate with their needs.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

Criterion 1.1.4.5 (HDS(C)S.2008:1.1.4.5)

The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs (HDS(C)S.2008:1.1.6)

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.

ARC D3.1g; D4.1c ARHSS D3.1g; D4.1d

Attainment and Risk: FA

Evidence:

The service establishes links with family/whanau or other appropriate representatives as required. Family meetings occur at admission, and at multi-disciplinary team meetings. The operations manager, clinical manager or registered nurse contacts family when required. Seven family members (four hospitals and three psychogeriatric) and four residents (from the hospital) confirm they are consulted regarding individual values and beliefs.

D3.1g The service provides a culturally safe service by implementing Millvale Levin's vision and values of care and service, which promotes the uniqueness of the individual and provides opportunities to enrich the lives of each resident. During the admission process, the registered nurse, along with the family/whanau completes the documentation. The assessment process and philosophy of care enables appropriate responses to individual cultural beliefs. Initial and on-going assessment includes gaining details of people's culture, beliefs and values. D4.1c There is a section around expressing spirituality and culture in the care plan.

Families are actively encouraged to be involved in their relative's care in whatever way they want. Two programmes developed for families called 'Orientation for Families' and "Sharing the Journey" involves education and practical assistance for families around caring for loved ones with dementia. Family and friends are able to visit at any time of the day and are actively encouraged to participate in the resident reviews. The service provides an intercultural awareness education programme for staff that was developed in partnership with the Office of Ethnic Affairs using their in-house Intercultural Course contextualised by the service to suit the aged care sector. Cultural safety is part of the orientation training and competency package.

ARHSS D4.1d Three psychogeriatric care plans reviewed included the resident's social, spiritual, cultural and recreational needs.

Criterion 1.1.6.2 (HDS(C)S.2008:1.1.6.2)

The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.

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

Standard 1.1.7: Discrimination (HDS(C)S.2008:1.1.7)

Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.

ARHSS D16.5e

Attainment and Risk: FA
Evidence: <p>There is an abuse and neglect policy, resident's code of rights policy, complaints policy and process, staff code of conduct, which includes discrimination and professional boundaries.</p> <p>Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. Qualified staff are, in addition, required to abide by a professional code of ethics. The code of conduct discusses consequences if the code of conduct is not followed.</p> <p>Complaints regarding any alleged harassment, coercion, discrimination or abuse of any kind by a staff member are fully investigated and may be dealt with via both the complaint management and disciplinary processes. Discussion with the operations manager and a review of complaints identified no complaints of discrimination, coercion or exploitation of residents except the incident noted in 1.1.3.</p> <p>Job descriptions include responsibilities of the position. Staff are aware of and alert to the potential for racial and sexual harassment. Performance appraisals are conducted and staff receive supervision. Discussions with seven family members (four hospitals and three psychogeriatric) and four residents (from the hospital) identify that privacy is ensured.</p> <p>Discussions with two caregivers (one from the psychogeriatric unit and one from the hospital) and one enrolled nurse (from the psychogeriatric unit) described how professional boundaries are maintained.</p> <p>ARHSS D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with two caregivers (one from the psychogeriatric unit and one from the hospital) and one enrolled nurse (from the psychogeriatric unit) could describe how they build a supportive relationship with each resident. Interviews with three families from the psychogeriatric unit confirmed the staff assist to relieve anxiety.</p>

Criterion 1.1.7.3 (HDS(C)S.2008:1.1.7.3)

Service providers maintain professional boundaries and refrain from acts or behaviours which could benefit the provider at the expense or well-being of the consumer.

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

Standard 1.1.8: Good Practice (HDS(C)S.2008:1.1.8)

Consumers receive services of an appropriate standard.

ARC A1.7b; A2.2; D1.3; D17.2; D17.7c ARHSS A2.2; D1.3; D17.2; D17.10c

Attainment and Risk: CI
Evidence: <p>A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.</p> <p>At service level, incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including on-going review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting. There are a number of quality improvement projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities.</p> <p>The annual education programme is comprehensive and includes programmes designed and implemented by the service: "Best Friends" is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular "Best Friends Approach to Dementia Care" (putting yourself in their shoes) training is carried out for all staff regularly and this is key to living their values and philosophy.</p> <p>Millvale Levin is divided into two small homes (one psychogeriatric and one hospital). The small homes mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel. The smaller homes also have a higher staff ratio.</p>

Criterion 1.1.8.1 (HDS(C)S.2008:1.1.8.1)

The service provides an environment that encourages good practice, which should include evidence-based practice.

Attainment and Risk: CI

Evidence:

Services are provided at Millvale Levin that adhere to the health and disability services standards. There is an implemented quality improvement programme that includes performance monitoring. There are well-developed manuals for all areas of the service and include management, human resource, clinical, health and safety, kitchen, laundry and activities. Policies, procedures, and associated implementation systems are in place to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards including those standards relating to the Health and Disability Services (Safety) Act 2001.

A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.

There is an internal audit schedule. It includes (but is not limited to): clinical compliancy, complaints management, environmental safety, health and safety, infection control, kitchen/food, household services, medications, quality and risk management, resident's admission, resident care, restraint minimisation, staff education, incidents and accidents, and asset and maintenance review.

Seven family members (four hospitals and three psychogeriatric) and four residents (from the hospital) interviewed spoke very positively about the care provided and were well informed and supported.

There are implemented competencies for all staff including caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.

Finding:

Benchmarking with other Dementia Care NZ facilities with psychogeriatric and hospital level care occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents, staff accidents) and clinical record audits. At service level, incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including on-going review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting (sighted). There are a number of quality improvement (QI) projects running and all staff, and families are encouraged and facilitated to have input in to the quality improvement activities. QI's are raised as a result of feedback, complaints, surveys, staff or management suggestions, ideas, and discussions at handover. Once completed the QI's are logged in the six monthly statistics for health and safety/infection control/quality. There is a quality and risk management plan for 2013 - 2014. The plan is reviewed monthly at quality meetings to measure progress towards meeting the programme objectives. The education programme includes a comprehensive orientation programme with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling, and restraint. All care staff are supported to complete first aid qualifications and the ACE programme including dementia unit standards. The annual education programme is comprehensive and includes programmes designed and implemented by the service: "best friends" is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular "Best Friends Approach to Dementia Care" (putting yourself in their shoes) training is carried out for all staff regularly and this is key to living their values and philosophy. At an organisational level, there is a diversional therapy coordinator to provide support to the diversional therapy team and provide diversional therapy services to residents as required. This person is based at Levin two days per week. There is a regional clinical manager (who is currently acting as the clinical manager at Millvale Levin until this role is filled) to lead and provide guidance to the clinical managers. All clinical managers meet annually to discuss clinical issues or policy changes. There is supervision for all registered nurses. Mentoring of staff by more senior members is facilitated. Non-violent crisis intervention training is on-going at Millvale Levin and intercultural awareness training has commenced. In-service education sessions include input from external specialists and clinical policies and procedures are updated to reflect good practice. Families are provided with two programmes called 'sharing the journey' and 'orientation for families'. These provide information and support for family members in understanding dementia. Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. Millvale Waikanae is divided into two small homes. The small homes (one for the hospital and one for the psychogeriatric unit) mean that the environment feels more normalised, and residents orientate to their environment more easily. Staff described how they get to know their residents well and family described getting to know staff well and the family-feel.

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

There is an open disclosure policy, a complaints policy and an incident/accident reporting policy. Seven family members (four hospital and three psychogeriatric) stated they and the resident were welcomed on entry and were given time and explanation about services and procedures. A family focus meeting is held annually and is chaired by a director. Advised by the operations manager that staff do not attend this meeting as it provides opportunities for residents/families to talk openly and freely. Outcomes of this meeting are fed back the operations manager and any issues that arise are dealt with through the quality improvement programme. The clinical manager and the operations manager have an open-door policy. Incident forms have a section to indicate if family have been informed (or not) of an incident/accident. Thirteen incident/accident forms were reviewed for five residents. In all 13 forms reviewed, contact with families after an incident/accident is documented on the incident forms and in the progress notes. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term residential care in a rest home or hospital – what you need to know" is provided to residents on entry. D16.1b.ii Residents/family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. D16.4b Seven family members (four hospital and three psychogeriatric) interviewed stated that they are always informed when their family member's health status changes or of any other issues arising. D11.3 The information pack is available in large print and advised that this can be read to residents. The service has policies and procedures available for access to interpreter services and residents (and their family/whānau). Management identified that if residents or family/whānau have difficulty with written or spoken English that the interpreter services are made available. ARHSS D16.1b.ii; The information pack and admission agreement included payment for items not included in the services. A site specific Introduction to Dementia unit booklet providing information for family, friends and visitors visiting the facility is included in our enquiry pack along with a new resident's handbook providing practical information for residents and their families.

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

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

Attainment and Risk: FA

Evidence:

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

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

Wherever necessary and reasonably practicable, interpreter services are provided.

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

Standard 1.1.10: Informed Consent (HDS(C)S.2008:1.1.10)

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.

ARC D3.1d; D11.3; D12.2; D13.1 ARHSS D3.1d; D11.3; D12.2; D13.1

Attainment and Risk: FA
Evidence: <p>There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. Residents have a medical guidance plan that covers admission to hospital and resuscitation. There is evidence of EPOA/GP and Clinical Manager participation in the medical guidance plan.</p> <p>Millvale’s philosophy includes an emphasis on getting to know the resident, spending time with them and treating them as if they were your "best friend". Interviews with staff and families supported that they have input and are given choices. Care plans and 24 hours multidisciplinary care plans demonstrate resident choice as appropriate.</p>

Criterion 1.1.10.2 (HDS(C)S.2008:1.1.10.2)

Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.

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

Criterion 1.1.10.4 (HDS(C)S.2008:1.1.10.4)

The service is able to demonstrate that written consent is obtained where required.

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

Criterion 1.1.10.7 (HDS(C)S.2008:1.1.10.7)

Advance directives that are made available to service providers are acted on where valid.

Attainment and Risk: FA
Evidence:

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

Standard 1.1.11: Advocacy And Support (HDS(C)S.2008:1.1.11)

Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.

ARC D4.1d; D4.1e ARHSS D4.1e; D4.1f

Attainment and Risk: FA
Evidence: <p>The right to access advocacy services is identified for residents/families. There is an advocacy and consumer support policy in place. Leaflets are available at the entrance. The information identifies whom to contact to access advocacy services. The information pack provided to residents prior to entry includes advocacy information. An independent advocate visits monthly.</p> <p>Staff are aware of the right for advocacy and how to access and provide advocate information to residents if needed.</p> <p>D4.1d; Discussion with seven family members (four hospital and three psychogeriatric) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they are aware of their access to advocacy services.</p> <p>ARC D4.1e, ARHSS D4.1f: the resident file includes information on resident's family/whanau and chosen social networks.</p>

Criterion 1.1.11.1 (HDS(C)S.2008:1.1.11.1)

Consumers are informed of their rights to an independent advocate, how to access them, and their right to have a support person/s of their choice present.

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

Standard 1.1.12: Links With Family/Whānau And Other Community Resources (HDS(C)S.2008:1.1.12)

Consumers are able to maintain links with their family/whānau and their community.

ARC D3.1h; D3.1e ARHSS D3.1h; D3.1e; D16.5f

Attainment and Risk: CI

Evidence:

D3.1h; Discussion with seven family members confirmed that they are encouraged to be involved with the service and care of the residents.

Visiting is actively encouraged. Relatives interviewed stated they could visit at any time. The service has visiting hours from 8.30 am to 8.30 pm and family interviewed report this is very flexible.

D3.1.e Interviews with two activity staff described how residents are supported and encouraged to remain involved in the community and external groups. The facility activity programme encourages links with the community. Activities programmes include opportunities to attend events outside of the facility including activities of daily living e.g. shopping. Entertainers are included in the hospital/psychogeriatric unit's activities programme. The activities coordinators described how outings in the van are tailored to meet the interests of the residents. Residents are encouraged to maintain outside interests as appropriate. Assistance with transport is provided as required.

D3.1h; ARHSS D16.5f: Discussion with seven families identified that they are encouraged to be involved with the service and care.

Criterion 1.1.12.1 (HDS(C)S.2008:1.1.12.1)

Consumers have access to visitors of their choice.

Attainment and Risk: CI

Evidence:

A family focus meeting is held annually and is chaired by a director. Advised by the operations manager that staff do not attend this meeting as it provides opportunities for residents/families to talk openly and freely. Outcomes of this meeting are fed back the operations manager and any issues that arise are dealt with through the quality improvement activities programme. The clinical manager and the operations manager have an open-door policy.

Finding:

The service, as part of its commitment to holistic care has implemented a series of education sessions for families and friends, this ensures that families are well informed and are part of, and informed about, their family member's care and condition. There an orientation for families course that is a voluntary for new families of residents to assist them with the transition into care. The orientation informs the family about dementia care provided at Millvale Levin. This includes a) dementia as a journey for both the resident and the family, b) provision of information to families, c) advice on communication, and d) provide a family support network. This course is followed by the 'Sharing the Journey' course; a short course for families of people with dementia based on the service's 'Best Friends Approach to Dementia Care'. The premise of the 'best friends' approach is that the service provides care and support that one could expect of a best friend. The course aims to enable family members to understand the dementia journey, and effective ways of both communicating with and managing their family member in care. Families interviewed (seven) were complimentary about the information received and the courses. Additionally the service contracts a family support person who can provide confidential and support to family members. Information about how to contact this person is included in welcome information and displayed at the facility. The seven family members interviewed are aware of this service.

Corrective Action:

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

Criterion 1.1.12.2 (HDS(C)S.2008:1.1.12.2)

Consumers are supported to access services within the community when appropriate.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. Complaints information is available in each unit and information is provided to residents and relatives at entry. There is an established and up to date complaints register that is also included on an access database format. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response. Specific QIs are raised from complaints. For 2013 (to date) there have been four written complaints. The complaints are well documented and managed. In June 2013 a family made a complaint to the Health and Disability Commission regarding the fact that the resident (in the psychogeriatric unit) had been assaulted on several occasions by other residents and the family are unhappy with the lack of psychogeriatric beds in the region meaning they have no ability to move their family member. The service provided full information including behaviour management strategies for the other residents involved to the Health and Disability Commission and on 11 October 2013, they received notification from the commission that no further action was required.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry. ARHSS D13.3g: The complaints procedure is provided to relatives on admission.</p>

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

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

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

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

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

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

Outcome 1.2: Organisational Management

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

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

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

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

Attainment and Risk: CI

Evidence:

Millvale Levin provides psychogeriatric and hospital (geriatric and medical) level care for up to 29 residents. On the day of audit, there were 16 residents in the psychogeriatric unit and 13 residents in the hospital unit. Only four hospital residents could be interviewed as the remainder could not cognitively be interviewed.

Dementia Care NZ is the parent company for Millvale Levin and has a current charter and business plan and a quality and risk organisational plan that aligns with the business plan (July 2013 to July 2014). The vision and values statement sets out the philosophy of the providers. Millvale Levin holds regular meetings including (but not limited to); quality, infection control, staff, health and safety and resident/family meetings. The operations manager of Millvale Levin reports to the proprietors on a range of issues on a monthly basis. An operations manager who is supported by a team of experienced staff - clinical nurse manager, registered nurses, caregivers and the management team of Dementia Care NZ manages the service. At the time of the audit the clinical manager position was vacant (a senior registered nurse from another Dementia Care New Zealand service has been appointed but has not yet commenced in the role) and the clinical manager position was being temporarily filled by the regional clinical manager who is an experienced registered nurse.

D17.4b (hospital), The operations manager is an experienced manager and has been with Dementia Care New Zealand since 2007, initially as a caregiver and ten since 2009 as home manager at another facility before commencing this role in February 2013. The clinical manager (currently filled by the regional clinical manager) provides clinical oversight. The organisation provides training days with the clinical managers and senior management team to ensure at least eight hours annually of professional development activities occurs including those related to managing a hospital.

The service is commended for the implementation of the organisation vision, values, goals and objectives including (but not limited to) promoting independence and valuing the lives of residents and staff.

ARHSS D5.1 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.

ARC, D17.4b (hospital), ARHSS D17.5 The manager has maintained at least eight hours annually of professional development activities related to managing a hospital.

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

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

Attainment and Risk: CI

Evidence:

Dementia Care NZ Ltd owns and operates Millvale Levin. Millvale Levin 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.

The philosophy of care incorporates: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and 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; c) small homely units provides residents with a stable and familiar environment; d) 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; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. The philosophy care is to promote participation in life activities, promote physical and emotional wellness.

Millvale Levin provides psychogeriatric and hospital (geriatric and medical) level care for up to 29 residents. On the day of audit, there were 16 residents in the psychogeriatric unit and 13 residents in the hospital unit. Only four hospital residents could be interviewed as the remainder could not cognitively be interviewed. The intention of the service is to provide a home-like atmosphere for residents.

Dementia Care NZ Ltd has well established business, strategic, quality and risk organisational plans being implemented for Millvale Levin. The operations manager of Millvale Levin 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 2013/2014. 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.

Finding:

Millvale Levin 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: a) the 'best friend' approach - acceptance, belief in the person, forgiveness, listening, and laughter; b) families/whanau become part of and 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; c) small homely units provides residents with a stable and familiar environment; d) 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; e) ensuring that residents can continue with their old roles if they wish, (like collecting the mail, folding the washing, or sweeping the floor) to promote a purposeful life and involvement in the running of their home. The philosophy care is to promote participation in life activities, promote physical and emotional wellness. This is well demonstrated at Millvale Levin. The service monitors performance in a number of ways and evidence of on-going improvements identified. The operations manager completes monthly reports that analysis internal audits completed, follow ups required, progress to meeting quality projects, corrective action status, document/review changes and general. Monthly incident trend analysis occurs and corrective action implemented as a result. Progress towards meeting the quality and risk management plan is monitored quarterly at organisational level and the entire plan reviewed and re-developed annually by the quality team. Meeting minutes for quality committee, health and safety committee and infection control committee are comprehensive and include review of the organisational and local objectives against performance measures. 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. Friends and family satisfaction surveys are completed annually and the 2013 survey indicates a very high level of satisfaction. Actions are identified and followed through as required because of the survey.

Corrective Action:

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

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

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

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

Standard 1.2.2: Service Management (HDS(C)S.2008:1.2.2)

The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.

ARC D3.1; D19.1a; E3.3a ARHSS D3.1; D4.1a; D19.1a

Attainment and Risk: FA
Evidence: During a temporary absence of the operations manager, the clinical manager assumes the role. D19.1a; A review of the documentation, policies and procedures and from discussion with staff identified that the service operational management strategies, QI programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality. There are relevant care and support policies including relevant clinical procedures for the management of hospital level residents. At Millvale Levin, there is currently a house GP, physiotherapist (visits two weekly currently) and a dietitian (visits monthly). There is also an organisational diversional therapy coordinator. At an organisational level there is are two regional clinical managers that provide clinical support and leadership. Allied health professionals are accessed on an as required basis. ARHSS D4.1a: The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and dementia and promotes quality of life.

Criterion 1.2.2.1 (HDS(C)S.2008:1.2.2.1)

During a temporary absence a suitably qualified and/or experienced person performs the manager's role.

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

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

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

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

Attainment and Risk: CI
Evidence: <p>Millvale Levin has a strategic business plan and a quality and risk management plan that are implemented and managed at service level by a quality services manager and quality team. There is an internal audit schedule and internal audits are completed. Progress with the quality plan is monitored through monthly quality meetings, weekly planning meetings with home managers, monthly registered nurse meetings, monthly health and safety meetings, monthly infection control meetings and monthly reports to the directors.</p> <p>The quality committee meeting includes (but is not limited to): infection control, accidents/incidents, restraint, quality goals, quality activities, policies and procedures, health and safety, staff, family issues, complaints, marketing, education and clinical issues. Minutes are maintained and easily available to staff in a folder. Minutes include actions to achieve compliance where relevant. Benchmarking is used as a means of identifying trends and potential risks or for advanced planning. This, together with comprehensive staff training, demonstrates the organisations and Millvale Levin's commitment to on-going quality improvement.</p> <p>D5.4 The service has the following policies/ procedures to support service delivery. A document and data control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived.</p> <p>The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident/accident policy. Incident/accident forms are completed and given to a registered nurse who completes the follow up. The operations manager who completes any additional follow up and collates and analyses data to identify trends sees all incident/accident forms. Results are discussed with staff through the monthly meetings including: registered nurse, quality committee, health and safety, infection control and the operations manager's monthly report to the directors/proprietors. Complaints/concerns are recorded in a complaints folder. There is a spread sheet/data base register in place. There is evidence that complaints/concerns are followed up, any concerns raised through resident meetings, family focus meeting, and friends, and family surveys are followed up and actioned. Infection control data is collated monthly and reported to the monthly infection control committee meeting, the quality committee meetings, and monthly staff bulletin. Actual and potential risks are identified and corrective actions initiated. This is discussed at the monthly quality meetings, monthly health and safety meetings and reported to the directors/proprietors in the operations manager's monthly report. A hazard identification register includes type, potential harm, action to minimise, control measures and checks. The hazard register is reviewed annually. A safe work booklet has been</p>

introduced for staff. Two health and safety goals have been identified for 2013. Restraint is reviewed at the monthly quality meetings and six monthly restraint approval committee.

Corrective actions are established because of internal audits, incidents, accidents, complaints and concerns. Corrective actions are discussed at staff meetings and quality meetings. Meeting minutes are documented using a corrective action format. Discussions with the clinical nurse manager, three registered nurse, two caregivers and one enrolled nurse described that corrective actions are implemented. Internal audits are completed. Corrective actions identify the actions required; the person responsible, documentation of actions completed and signed completion. The QI log identified new quality initiatives. An example of the service identifying and responding to issues through internal audits and corrective action planning is that in September 2013 an internal audit identified that the GP was not consistently documenting indications for use when prescribing PRN medications. A corrective action plan was developed in discussion with the GP (confirmed at interview) and the GP now documents indications for use for any new PRN medications and is documenting this for existing PRN medications as each resident has their three monthly medication review.

D19.3 There are implemented risk management and health and safety policies and procedures in place including incident/accident and hazard management. The health and safety policies include (but are not limited to): hazard identification; hazard management; staff responsibilities; employee participation in health and safety systems. A hazard register is reviewed annually. Hazard identification forms are completed to identify hazards with actions identified and reviewed/followed up where appropriate. The monthly health and safety meetings identify actual and potential risks and corrective actions are initiated. Monthly incident/accident data are collated and actual and potential risks are identified.

D19.2g Falls prevention strategies are in place that include: assessment of risk, medication review, bone health introducing vitamin D, vision and hearing assessments, mobility assessments with physiotherapy input, exercises/physical activities, training for staff on detection of falls risk, and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.

ARHSS: D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.

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

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

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

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

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

Attainment and Risk: CI
<p>Evidence:</p> <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 registered nurse; quality committee; infection control; health and safety; and internal management. Minutes reviewed document the discussion of all quality activities.</p> <p>The service has an internal audit schedule that is implemented. Internal audits are completed and actions identified.</p>
<p>Finding:</p> <p>Quality data gathered 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 on-going evaluation of action undertaken. Audit results are collated and document. Results are then fed back to staff at appropriate forums, e.g. staff, health and safety meeting. Meeting minutes reflect a culture of quality improvements and on-going review of practice. An example of this is an internal audit conducted in September 2013 the service identified that not all PRN medications charted had a documented indication for use. A quality improvement plan was implemented and discussion held with the doctor around this (confirmed at interview with the doctor). The plan developed included that as the GP reviews medication files he will ensure that PRN medications are charted correctly. While this process is not yet completed and a corrective action has been raised in this audit around PRN medication charting the service has identified the issue and begun addressing it through their internal audit and corrective action planning process. Monthly benchmarking analysis is completed that includes outcomes. Resident and family are provided with quality feedback and initiatives through newsletters and meetings. Internal management meetings include a quality focus for the week. The quality meeting includes a discussion of new quality improvements, unresolved/outstanding quality improvements. The service is proactive in identifying quality improvements on an on-going basis and monitoring these until signed out as completed. In June 2013, the service identified that they had 16.67 falls incidents per 1000 bed days. This was lower than the reported falls in May 2013 but slightly higher than the 2012 average of 15.26. This falls rate was also the highest compared to other similar units in the organisation. The service identified residents at high risk of falling, reassessed them, and implemented individual measures resulting in a lowered rate of falls for July 2013. Millvale Levin also identified that in June 2013 16.67 resident behaviour incidents occurred per 1000 bed days and while this was lower than the previous month it was higher than the average for 2012 (12.18). The rate was also higher than three of the four facilities benchmarked against. As a result monitoring was increased for residents who exhibit on going BPSD episodes than others and staff were encouraged to employ the services 'knack' approach and were reminded about triggers and the need for early intervention. Behaviour incidents have trended downwards since this time.</p>
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: CI
<p>Evidence:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Monthly internal benchmarking against similar services within the organisation in areas including (but not limited to) resident accidents and infections, staff accident are used to measure the effectiveness of the objectives of the quality and risk management plan.</p> <p>Resident meetings occur monthly in the dementia unit and the hospital unit and an annual family focus group is held.</p>
<p>Finding:</p> <p>The service is proactive in monitoring outcomes from their quality management programme through meetings, and quality reports 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/RN monthly report, education co-ordinator monthly report, quality and systems manager monthly report, activities team monthly report, marketing monthly report, and home managers' report. On-going quality improvements are monitored through all meetings and annual goals are evaluated. The family focus group meeting is held annually (last Oct 12) with the two directors and five participants. An action plan was completed as a result of areas family members would like to improve. Interview with a relative that was involved in that meeting spoke positively about the openness of the directors to make improvements. The October 2013 meeting has not yet occurred and an organisation wide quality improvement plan has been developed around this with the meeting scheduled to occur in February 2013. Team gathering meetings with staff throughout 2013 included input into reviewing previous business goals and developing goals for 2013- 2014. Six-week post admission surveys provide early feedback to the service friends and family satisfaction surveys are conducted annually.</p>
Corrective Action:
Timeframe (days): <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.

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

Attainment and Risk: FA
Evidence: D19.3d The service is aware that they will inform the DHB of any serious accidents or incidents. Discussions with the operations manager and regional clinical manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required. A review of 13 incident forms identified they were all fully completed and followed up appropriately by the RN including completing neuro obs for three residents, when the

residents fell and hit their head.

Minutes of the monthly quality and health and safety meetings, registered nurse, management meetings and the monthly staff bulletin reflect a discussion of incidents/accidents and actions taken. Benchmarking includes an analysis (link 1.2.3.6). The service analyses the trends and a comprehensive report is completed that includes outcomes and further actions required at a facility and organisational level. A regular review is completed of frequent falls (link 1.2.3.6).

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

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

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

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

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

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

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

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

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

Attainment and Risk: CI

Evidence:

Millvale Levin employs 38 staff. The staff orientation policy and procedures includes training and support packages for operations manager, registered nurses, caregivers, activities team, cook, and kitchen staff. There are job descriptions available for all positions and staff have employment contracts.

Six staff files were reviewed (one cook, one diversional therapist, two caregivers, one enrolled nurse and one registered nurse). Job descriptions were evident in all files reviewed. Performance appraisals are up to date. Reference checks are completed before employment is offered and are evident in the six staff files reviewed.

The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates sighted for all registered nurses, and allied/medical staff.

There are comprehensive human resources manual, which includes policies around recruitment, selection, orientation and staff training and development.

Orientation programme and packages for all roles. All six files reviewed showed evidence of orientation to roles with competency packages completed. The orientation programme is relevant to the psychogeriatric unit and includes a session how to implement activities and therapies.

The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Two caregivers and one enrolled nurse interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.

Competency packages for registered nurses include - 'Best Friends' approach to care, restraint minimisation and safe practice, first aid, ACE dementia series, delirium, syringe driver, medication, neurological conditions and leadership. Caregivers competency package - 'best friends' approach to care, restraint minimisation and safe practice, first aid, taking vital signs, safe medication administration, ACE programme and leadership. All staff also complete safe food handling, chemical safety, safe manual handling (hoist use), bi-cultural awareness and infection control.

The education coordinator manages a spread sheet of all staff and records all completed orientations, competencies and education attended.

ARHSS D17.1: There are 20 caregivers at Millvale Levin. Seventeen caregivers have completed the required dementia standards and three are in the process of completing. The three still completing have been at the service less than three months. There is an in-service calendar completed for 2013 and currently being finalised for 2014. 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.

The service is commended for the number of quality initiatives based around education of staff and relatives.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

Attainment and Risk: CI

Evidence:

Education plan for 2013-2014 is an objective of the quality and risk management plan. Human resource manual includes - training and supervision, staff training, ACE programme, maintaining training records, performance management and appraisals policy and procedures.

ARHSS D17.1: There are 20 caregivers in the psychogeriatric. Seventeen caregivers have completed the required dementia standards and three are in the process of completing. The three still completing have been at the service less than three months.

Discussion with the education coordinator for the organisation, the operations manager, regional clinical manager, three registered nurses and two caregivers confirm that a comprehensive in-service training programme is in place that covers relevant aspects of care and support and meets requirements. There is an in-service calendar completed for 2013 and currently being finalised for 2014. 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. Two caregivers and one enrolled nurse interviewed advised that they have all completed the ACE dementia training. The registered nurses attend external training days through the organisation.

An education coordinator is employed 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.

Finding:

A number of education initiatives are implemented at Millvale Levin. The annual education plan is comprehensive and covers both compulsory and additional topics. Topics are included in the plan in response to and following feedback from audits (i.e.: fire competency re-written to include more relevant questions), complaints, incidents/accidents, infection, meeting minutes, health and safety issues and quality improvement initiatives. The organisation has developed a programme called 'best friends', which comprises four x one-hour sessions for all staff. 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. This year the training has further extended with the introduction of 'come into my world' training, which is across three sessions. The 'Best Friends Approach' was developed in the USA. Dementia Care New Zealand have adapted the course and contextualised it to NZ culture, but the essence remains: if staff treat the people we are caring for as they would a best friend, then the person will receive the best of care. The course examines the experience of dementia from the perspective of the person with dementia and the ageing process. It looks at how to develop empathy by using interactive tools. They also explore the qualities of a best friend, the importance of knowing a person's life story and some communication role-plays. Finally the course focuses on how best friends communicate and how activities can be used to achieve well-being. Feedback from staff who have attended includes: "I've got a way now to help them and make them feel good," "Good to remember that this is their home and the staff are visitors to their home", "I am more confident about being around residents" and "This course has made me look forward to having 'magic moments' with the residents." Dementia Care NZ developed 'Come Into My World' as an extension of the Best Friends Approach and much of this course based on validation therapy. Some of the techniques and approaches explored are reminiscence, using music to remember, rephrasing what a person with dementia has said to us, mirroring behaviour and communication. The course is interactive with lots of role-plays around how people communicate and attempt to validate and accept the emotions of the person with dementia. The philosophy includes that our emotional needs remain with us from the cradle to the grave and to be accepted by others is as valuable as other care we receive. Feedback from staff who have attended the training includes: "Interesting to learn about Malignant Social Psychology and role-plays to reinforce empathy," "Great new techniques to help me interact with the residents" and "A great insight into the resident's world view."

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Rosters are in place and show staff coverage across the hospital and psychogeriatric unit. There is an RN based on duty 24/7 in the psychogeriatric unit and another RN rostered on morning shift in the weekends.

The RNs oversee the hospital and PG units.

Operations Manager Mon - Fri and Clinical Manager (RN) - five days a week.

Interviews with four residents, seven relatives, three registered nurses, one enrolled nurse and two caregivers confirmed that staffing levels are good across each area.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.2.9: Consumer Information Management Systems (HDS(C)S.2008:1.2.9)

Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.

ARC A15.1; D7.1; D8.1; D22; E5.1 ARHSS A15.1; D7.1; D8.1; D22

Attainment and Risk: FA

Evidence:

The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in offices. Resident records are kept up to date and reflect residents' current overall health and care status. Staff can access records appropriately.

D7.1 Entries are legible, dated and signed by the relevant staff member including designation.

Individual resident files demonstrate service integration. This includes medical care interventions and records of the diversional therapist. Medication charts are in a separate folder.

Criterion 1.2.9.1 (HDS(C)S.2008:1.2.9.1)

Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.

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

Criterion 1.2.9.7 (HDS(C)S.2008:1.2.9.7)

Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

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

Criterion 1.2.9.9 (HDS(C)S.2008:1.2.9.9)

All records are legible and the name and designation of the service provider is identifiable.

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

Criterion 1.2.9.10 (HDS(C)S.2008:1.2.9.10)

All records pertaining to individual consumer service delivery are integrated.

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

Outcome 1.3: Continuum of Service Delivery

Consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Standard 1.3.1: Entry To Services (HDS(C)S.2008:1.3.1)

Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.

ARC A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2; E3.1; E4.1b ARHSS A13.2d; D11.1; D11.2; D13.3; D13.4; D14.1; D14.2

Attainment and Risk: FA

Evidence:

There are pre-entry and admission procedures in place. Residents are assessed on entry to the service and needs assessments are sighted on the six (three hospital and three psychogeriatric) sampled. The service liaises with assessment services and service coordinators as required. The service has a good relationship with the assessor's base at STAR 1 Midcentral DHB. The service is pro-active in the community and maintains good relationships with groups such as Alzheimer's Society/Age concern/RSA. Currently there is no waiting list.

The service has a well-presented information booklet for residents/families/whanau at entry. It is comprehensive and designed so it can be read with ease (spaced and larger print). Promotional material is available on the company website. The service has implemented "sharing the journey" family support group to assist them with coming to terms with a resident with advanced dementia and provides education, care and support for the family. Seven family (four hospital and three psychogeriatric) members interviewed state they received sufficient information on the services provided and are appreciative of the staff support during the admission process.

D13.3 The admission agreements reviewed (four hospital and three psychogeriatric) aligns with a) -k) of the ARC contract.

D14.1 Exclusions from the service are included in the admission agreement.

D14.2 The information provided at entry includes examples of how services can be accessed that are not included in the agreement.

Criterion 1.3.1.4 (HDS(C)S.2008:1.3.1.4)

Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.2: Declining Referral/Entry To Services (HDS(C)S.2008:1.3.2)

Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.

ARHSS D4.2

Attainment and Risk: FA

Evidence:

The reason for declining service entry to residents is recorded should this occur and communicated to the resident/family/whanau. The regional clinical manager (CM) staff report that the referring agency or Support Links would be advised when a resident is declined access to the service and it is then their responsibility to inform the resident/family/whanau of other options that may assist them to meet their needs.

Criterion 1.3.2.2 (HDS(C)S.2008:1.3.2.2)

When entry to the service has been declined, the consumers and where appropriate their family/whānau of choice are informed of the reason for this and of other options or alternative services.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

Millvale House provides a caring homely environment for its residents to assist with normalising the service. The service provides hospital level of care in Haumaru “home” and psychogeriatric level of care in Aroha Nui “home” within the same facility. The staff are committed to valuing each resident as an individual and practice the “Best Friends” approach to care and activities. Establishing relationships with families is achieved with community visits and bringing together families together “sharing the journey” at family support groups. Guest speakers such as lawyers, Age Concern and Alzheimer’s speakers attend the meetings. Relatives spoke highly of the all the staff, the care, activities programme, medical care and the environment.

D16.2, 3, 4. Three hospital files and three psychogeriatric files sampled identified that in all six files an assessment was completed within 24 hours and all six files identify that the long term care plan was completed within three weeks. There is documented evidence that the care plans are reviewed by a registered nurse (RN) and amended when current health changes. All six care files evidenced multidisciplinary reviews completed at least three monthly.

D16.5e; Five resident files sampled identified that the general practitioner (GP) had seen the resident within two working days. One psychogeriatric resident was admitted from STAR 1 with medical discharge summary form and relevant information and admitted by the home GP within three days. It is noted in resident files reviewed that the GP has assessed the resident as stable and is to be seen three monthly or more frequently should the residents health status change.

The general practitioner (GP), interviewed, is currently contracted to Millvale house for weekly visits. The GP is involved in the three monthly multidisciplinary (MDT) reviews and conducts a three monthly resident examination and medication review. There is a GP on call system after hours.

The physiotherapist visits fortnightly for 1.5 hours to assess any new residents, attend the six monthly reviews, update resident transfer plans and follow-up any concerns written into the physiotherapy communication book. The physiotherapist is also involved in the assessment/purchase of equipment.

The podiatrist visits six weekly. The dietitian visits monthly and is involved in resident reviews where applicable and readily available (by visit and email) to the clinical and food services team for any advice or resources. Allied health professionals record visits in the integrated notes.

The Arohanui hospice nurses and specialists visit residents under their care for specific needs and palliative cares. Liverpool care pathway is in place for end of life cares at Millvale house.

One enrolled nurse and two caregivers interviewed described verbal and written RN handovers. Handover was observed in the psychogeriatric unit. The information given at handover is sufficient to provide continuity of care to the residents. The RN's state the caregivers are very prompt in reporting any resident health changes or incidents. Caregivers and RN's write entries into the progress notes on each shift. A resident daily hygiene cares and bowel chart is maintained for every resident.

ARHSS D16.6; Three residents files sampled with behaviours that challenge were reviewed from the psychogeriatric unit. Behaviours in all three files were well identified through the assessment process, 24 hour MDT management plans implemented, resident behaviour charts and behaviour monitoring is in use for exacerbation of behaviours or new behaviours. The community psychiatric nurse visits regularly and liaises closely with the elder health and psychogeriatric team based in STAR 1 at Midcentral DHB. The community psychiatric nurse visits all new admissions to Haumarua at least weekly for three weeks. Residents are then discharged from her care and visits continue as required. The elder health team respond promptly to urgent concerns.

Tracer methodology;

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

Tracer methodology; Hospital level care resident

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

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

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

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

Standard 1.3.4: Assessment (HDS(C)S.2008:1.3.4)

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.

ARC D16.2; E4.2 ARHSS D16.2; D16.3d; D16.5g.ii

Attainment and Risk: FA

Evidence:

The information gathered at admission and health assessment form is used to develop care needs, aims and actions to provide best care for the residents. There is an on-going assessment of resident's policy that includes assessments that should be in place and timeframes. RN's complete initial assessments within 24 hours of admission.

A range of assessment tools are completed on admission and reviewed at least three monthly as applicable and include (but not limited to); continence assessment, falls risk, St Thomas risk assessment in falling elderly residents, Braden pressure area tool, Abbey pain assessment, wound, nutritional screening and activity initial assessment. There are other allied health assessments completed such as dietitian assessment and physio assessment. The diversional therapist also completes a comprehensive social assessment. Assessments are conducted at the facility in agreement with the resident/family member or EPOA. Residents have private rooms where they can be assessed

ARHSS D16.5gii Three resident files sampled included an individual assessment that included identifying diversional, motivation and recreational requirements.

Criterion 1.3.4.2 (HDS(C)S.2008:1.3.4.2)

The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.3.5: Planning (HDS(C)S.2008:1.3.5)

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.

ARC D16.3b; D16.3f; D16.3g; D16.3h; D16.3i; D16.3j; D16.3k; E4.3 ARHSS D16.3b; D16.3d; D16.3e; D16.3f; D16.3g

Attainment and Risk: FA

Evidence:

Care plans are developed and reviewed by the RN's. The long term care plan is developed within three weeks of admission. The care plan plans are comprehensive; meets resident's needs, and includes diagnosis/needs, aim and action. The first page of the long term care plan includes the resident details, medical problems, any special needs and name and signature of the resident/family member/EPOA who has participated in the development of the long term care plan. The long term care plan describes needs as follows: hygiene and grooming, mobility, nutrition, continence, communication, cultural, rest and sleep, skin integrity, behaviour, medical and pain needs. The DT and RN complete a 24 hour MDT (multidisciplinary) care plan. The MDT care plan details the residents morning and afternoon habits, behaviours, activities or diversions that work, nocte pattern, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation. The activities person and/or family complete a resident activity profile sheet. The activity care plan identifies the resident's individual values, beliefs, spirituality and culture.

Each resident file has an interventions/special instructions form placed on the front of the file. Resident handling and care guides are placed inside each resident's wardrobe for quick reference for caregivers.

Service delivery plans demonstrate service integration. Resident files are integrated and include; a) admission details, b) permissions, consents, c) activities profile, d) restraint (if applicable, e) property list, f) significant events.gh) LTCP and 24 hour care plan , h) activities plan, i) STCP, j) progress notes, k) incident forms, l) all assessments, m) allied health input, n) GP and other medical notes, o) lab results, p) NASC and q) correspondence.

ARHSS 16.3g: Three psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. All three residents had comprehensive behaviour management plans, behaviour charts and behaviour monitoring

D16.3k, Short-term care plans are used for short term needs. Short term care plans sighted are for painful above knee amputation and supra pubic catheter.

D16.3f; All resident files reviewed identified that family were involved. Relatives interviewed (four hospital and three psychogeriatric) confirm they are involved in the care planning process.

Criterion 1.3.5.2 (HDS(C)S.2008:1.3.5.2)

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.3.5.3 (HDS(C)S.2008:1.3.5.3)

Service delivery plans demonstrate service integration.

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

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

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

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

Attainment and Risk: FA
Evidence: <p>The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussion with caregivers, registered nurses, activity staff and management. The care plans are well written, in-depth and reflect the service philosophy of care and support. Relatives interviewed states their relatives needs are being met. The staff and facilities are appropriate for providing hospital and psychogeriatric services and are meeting the needs of residents. D18.3 and 4. Wound assessments are comprehensive and include type, location and body map/graph, photograph as applicable, Braden score, cause, classification, factors delaying healing and any additional information such as referrals. A wound dressing schedule describes dressing types, objectives and reviews. There are wound assessment plans and wound dressing schedules for one surgical wound (above knee amputation) and skin tear of hand in the hospital unit. There are no wounds in the psychogeriatric unit. There are no pressure areas. Pressure area resources are available as required. Specialist wound and continence management advice is available as needed and the clinical manager interviewed could describe this. Adequate dressing supplies are sighted. A skin tear kit is readily available for staff to access.</p> <p>Continence assessments include a urinary and bowel continence assessment are completed on admission and reviewed three monthly. Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained. The company has recently appointed a continence resource person.</p> <p>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) with known pain or suspected pain identifying behaviours that could be displayed in residents experiencing discomfort or pain. Pain assessments are reviewed for new episodes of pain, changes in pain relief or pain management. Pain monitoring forms used to monitor the effectiveness of pain relief are kept in the medication chart folder. Episodes of pain and management of pain are also recorded in the progress notes. Pain management and pain relief is reviewed three monthly by the GP and MDT team.</p>

The dietitian visits monthly and completes any resident reviews due and attends to any referrals received for example residents with weight loss, initiates special authority for supplements and liaises with the cook regarding any resident dietary changes/requirements. Residents are weighed monthly or more frequently as per the weight loss management policy. The dietitian maintains progress notes in the integrated resident file. Staff record food and beverage intake on recording charts. Prescribed dietary supplements administered are signed on the nutritional supplement signing chart in the medication folder.

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

Monitoring forms in use included behaviour monitoring, blood sugar levels, neurological observations and vital signs. RN faxes to GPs regarding changes in resident health status, suspected infections, new admission, and medication requests sighted in the resident files sampled.

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

Challenging behaviour assessments are well documented with excellent follow up into care plans for the hospital and psychogeriatric resident files sampled. Behaviour monitoring forms are used to record behavioural or disruptive actions and describe distraction techniques. A 24 hour MDT (multidisciplinary) care plan details the residents morning and afternoon habits, behaviours, activities or diversions that work, nocte pattern, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation. A behavioural and psychological symptoms of dementia (BPSD) advisor role has been established at Millvale house – Levin. Thirty three staff have attended non-violent crisis intervention education for 2013.

ARHSS D16.4; There is good specialist input into residents in the psychogeriatric unit. The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment.

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

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

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

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

Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.

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

Attainment and Risk: FA

Evidence:

The company diversional therapy (DT) team leader is employed for four days a week at Millvale house – Levin and one day a week oversees and supports the activities teams in all Dementia Care N.Z. facilities. The activity team of three provide group and one on one activities in the hospital unit 1 – 4.30pm Monday to Friday and 1-5pm in the psychogeriatric unit. One activity person is currently completing the orientation programme. The hours and timing of activities are monitored to ensure the programme is best suited to the resident needs. Varying activities occur simultaneously in both the units. The activity staff liaise with the RN at the beginning of their shift for a resident update. The team meet monthly to plan the separate programmes for each unit that meets the individual needs, strength, skills and abilities. The hospital programme is flexible to meet the needs of the residents and include (but not limited to); exercise, music, knitting group, movies, quiz and board games, manicures and foot spas, floral arrangements, garden time and crafts.

The psychogeriatric programme are focused on household/meaningful tasks, reminiscing and sensory activities such as manicures and foot spas, baking, garden walks, lawn games/ice-creams, games, exercises, magazines and poetry and music. Live music entertainment is provided every Saturday and is open to residents from both units under supervision. A volunteer takes bible readings and prayers every Sunday. Church singers visit the home and residents maintain contact church groups as desired. The residents enjoy children and pet visits. Ethnic and cultural preferences are met with celebrations such as Chinese new year and Matariki (Maori) new year. Birthdays are celebrated. The van (with wheelchair access) is available three days a week for outings. One DT and volunteer or other staff member supervise residents on outings. The DT's have first aid certificates. Activity assessments, activity plan, 24 hour MDT plan, progress notes and attendance charts are maintained. Resident meetings are held in both units. There are regular family meetings as well as one on one feedback on the activity programme.

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

ARHSS 16.5g.iv: Caregivers are observed various times through the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions. Activities are observed occurring in both “homes” simultaneously.

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

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

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

Attainment and Risk: FA

Evidence:

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

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

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

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

Attainment and Risk: FA
Evidence: Nursing care plans are reviewed three monthly by the MDT team are evaluated at least six monthly or earlier due to health changes. The MDT includes the nursing and care staff, DT, GP, physio, family/whanau/EPOA as appropriate. Other health professionals are involved as appropriate. Short-term care plans are reviewed as required and are resolved or if an on-going problem added to the long term care plan. There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes. There is evidence of on-going review and changes to care plans. The three monthly written reviews cover resident recordings (weight, blood pressure, and pulse), physical examination, restraint (if applicable), behaviour, family discussions, medication review and falls (if relevant). ARHSS D16.3c: the RN evaluated all initial care plans within three weeks of admission. D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

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

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

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

Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) (HDS(C)S.2008:1.3.9)

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.

ARC D16.4c; D16.4d; D20.1; D20.4 ARHSS D16.4c; D16.4d; D20.1; D20.4

Attainment and Risk: FA
Evidence: The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained. There is good communication with the GP's, mental health for the older person's team and the psychogeriatric services. Family/whanau/EPOA is involved as appropriate when referral to another service occurs. Referrals sighted in the resident files sampled include; occupational therapist, older adult community psychiatric nurse, old age psychiatry services, physiotherapist, palliative care co-ordinator, dentist, dietitian, rheumatologist, urology nurse specialist, podiatry, wound nurse and diabetes nurse. D16.4c; The service liaises closely with the needs assessment team. Currently there are no examples of where a resident's condition has changed and required reassessment for a higher level of care. D 20.1 Discussions with registered nurses identified that the service has access to dietitian, physiotherapy, speech language therapist, wound care specialist, podiatrist and mental health nurses and practitioners, hospice nurses and specialists.

Criterion 1.3.9.1 (HDS(C)S.2008:1.3.9.1)

Consumers are given the choice and advised of their options to access other health and disability services where indicated or requested. A record of this process is maintained.

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

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer (HDS(C)S.2008:1.3.10)

Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.

ARC D21 ARHSS D21

Attainment and Risk: FA
Evidence: There is a discharge planning and transfer policy and resident transfer to hospital (acute) policy guide staff in this process. Discussions with the service confirm that resident exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of residents care through the completed internal transfer form, copy of relevant progress notes, copy of medication chart and doctor's notes. A staff member or family member (as appropriate) accompanies the resident to the hospital.

Criterion 1.3.10.2 (HDS(C)S.2008:1.3.10.2)

Service providers identify, document, and minimise risks associated with each consumer's transition, exit, discharge, or transfer, including expressed concerns of the consumer and, if appropriate, family/whānau of choice or other representatives.

Attainment and Risk: FA
Evidence: .
Finding:

Corrective Action:

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

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

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

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

Attainment and Risk: FA

Evidence:

The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice including, but are not limited to: a) medication management, b) medication charting c) standing orders, d) medication storage, e) blister pack management, f) medication administration, g) specific medication devices (such as spacers, oxygen, IV therapy, sub-cut fluid administration, novo-pen, etc.) h) medication errors, i) emergency medications, j) staff training, k) storage and administration of controlled drugs, l) alternative medication and m) medication audit.

The service uses robotic system for regular medication and medico blister packs for PRN medications. The RN checks these on arrival from the supplying pharmacy located in Lower Hutt. A local pharmacy is available after hours to the service for urgent requests. The pharmacy monitors crushed medications for appropriateness. Medication reconciliation is implemented via the 'medication management on admission and transfer policy'. RN's administer medications in the hospital and psychogeriatric units. Orientation to medications includes a self-learning package and supervised medication rounds. Annual competency and medication education has been completed in July 2013. Emergency oxygen and suction (checked September 2013) and a portable emergency kit is available. Liverpool care pathway (LCP) is in place for end of life/palliative care. RN's have completed syringe driver education and refreshers. LCP medications are held in controlled drug safe in the hospital unit. Arohanui hospice nurses and specialists support the staff.

The medication folder contains specimen signature list, current standing orders, resident abbey pain scales and monitoring as applicable, signing sheets for nutritional supplements, alert labels for controlled drugs and crushed medications and monitoring of reduction of psychotropic medications (as appropriate). There is one main medication and treatment room located within the hospital unit. All medications are stored safely. A controlled drug is maintained with weekly checks. There is a pharmacy audit completed six monthly. The medication fridge is monitored daily. All eye drops in the medication trolley are dated on opening. There are no self-medicating residents at the facility.

The medication charts are computer generated by the pharmacy monthly. The medical notes state the GP has undertaken a three monthly review of the medications. There is a requirement for all prn medications prescribed to have an indication for use. All medication charts had current (dated) photo identification and allergies noted. Special medication instructions and precautionary advice is recorded on the medication charts. There are no gaps in the administration signing sheets. Administration of controlled drugs is signed by two persons, one being the RN. Medication administration observed in the hospital unit complied with medication policy and procedure. The medication charts are computer generated by the pharmacy monthly. The GP reviews the medications at least every three months. All prn medications administered are dated and timed. Nine of 12 medication charts sampled had indications for use of prn medications prescribed. This is continually being monitored by the service. D16.5.e.i.2; Twelve medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed.

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

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

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:
Timeframe (days): 60 <i>(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)</i>

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

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

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

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

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

Attainment and Risk: FA
Evidence:

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

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

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

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

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

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

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

Attainment and Risk: FA
Evidence: <p>There is a kitchen service manual located in the kitchen, which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. There is a cook on duty each day from 7am to 5.15pm to prepare, cook and serve the meals (includes breakfast). A tea aide is on duty from 16.45 to 1845pm to assist with the evening meal, supper and cleaning duties (cleaning schedules sighted). All staff have attended food safety and hygiene, chemical safety and relevant in-service offered on-site. The kitchen is located within the hospital end of the facility and meals are directly served to residents in the hospital dining room. Meals are plated and transported in hot boxes to the psychogeriatric dining room. There is a four weekly summer menu in place that has been reviewed by the company dietitian. All cooking and baking is done on site. The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Mouli and normal diets are provided. Resident likes and dislikes are known and alternative foods are offered. Cultural and spiritual needs are met. One resident has a special menu with family, GP and dietitian input to abide with family wishes for the use of coconut oil in the foods. Lip plates and specialised utensils are available as needed to promote independence at meal times. There are additional nutritional snacks available for residents and staff have open access to the kitchen. There is daily monitoring of hot food temperatures, chiller, fridge and freezer temperatures and dishwasher rinse temperatures. All perishable foods in the fridge is dated.</p>

The dry good store have all goods sealed, labelled and off the floor. Goods are rotated with the weekly delivery of food items. The cook is observed wearing appropriate personal protective clothing. There are fly screens on the windows and a pest management programme in place. Chemicals are stored safely within the kitchen. There is a planned maintenance schedule for the equipment and cleaning of high walls and ceilings (records sighted).

ARHSS D15.2f: There is evidence that there are additional nutritious snacks available over 24 hours. Sandwiches, cakes, protein drinks and deserts are available in the kitchen fridge.

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

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

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

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

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

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

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

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

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

Outcome 1.4: Safe and Appropriate Environment

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Standard 1.4.1: Management Of Waste And Hazardous Substances (HDS(C)S.2008:1.4.1)

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.

ARC D19.3c.v; ARHSS D19.3c.v

Attainment and Risk: FA
Evidence: <p>The service has in place management of waste and hazardous materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. These include, but are not limited to: a) sharps procedure and b) cleaning/chemicals procedures and c) exposure to blood or other body fluid contamination policy. There is an incident reporting system that includes investigation of these types of incidents.</p> <p>Chemicals are labelled correctly and stored safely throughout the facility. A chemical spills kit is available. Staff are observed wearing protective equipment and clothing carrying out their duties. Gloves, aprons and face shields are available for staff in the sluice room, cleaners and laundry room. Staff have attended chemical safety training August 2013. The chemical supplier provides safety data sheets and conduct quality control checks on the effectiveness of chemicals. Waste management contractors deliver and collect the skips bins. Infectious material is double bagged and disposed of into the general waste bin. Recycling and organic waste is collected weekly. Approved containers are used for the safe disposal of sharps. Staff interviewed were able to describe waste management and chemical safety procedures.</p>

Criterion 1.4.1.1 (HDS(C)S.2008:1.4.1.1)

Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.

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

Criterion 1.4.1.6 (HDS(C)S.2008:1.4.1.6)

Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.

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

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

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

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

Attainment and Risk: FA

Evidence:

Millvale House has a current building warrant of fitness that expires 31 October 2014. The main entrance to the building has call bell access afterhours and opens up into the main reception and administration area. The facility is divided into two "homes" which are Haumarū (hospital) with 13 beds and Aroha Nui (psychogeriatric) 16 beds. There is secure access to the entrance of the psychogeriatric unit. Each unit has a nurse's station. Wireless network has been installed into the psychogeriatric unit nurses' station to allow the clinical manager to be based in the unit to observe the residents and be more readily accessible to staff. Staff tearoom, kitchenette, meeting room, administration offices and staff amenities are upstairs. The two units are spacious and wide corridors allow for the use of mobility equipment. Handrails are in place within the communal areas.

A maintenance person is employed full time and covers maintenance required at Millvale House. Maintenance requests are logged into a maintenance book kept in the nurse's station. Minor maintenance requests and repairs are addressed and signed off. External contractors are contacted for larger repairs. The maintenance person reports to the operations manager. There is a monthly maintenance planner that includes internal and external maintenance.

Electrical equipment is tested and tagged every two years. Clinical equipment is checked for function and calibrated annually (last in August 2013). Hot water temperatures are monitored weekly rotating the resident bedroom hand basins and shower areas. The carpets are routinely cleaned using the "rug doctor" machine. The maintenance person has the use of a company utility van.

Three months ago, the owner/operators purchased the next-door property and there have been continual improvements made to extend the outdoor areas for both "homes". There is a large deck with ramp access extending from the hospital lounge. Shaded areas are available and there are automated awnings over the lounge windows. The psychogeriatric "home" has exit and entry access from several doors within the unit. There is easy and safe access to the new deck extension from either the lounge, large or small dining area. There are plans to insert another set of double doors into the communal lounge that will increase the number of walking pathways. Each "home" has a high wooden fence around the perimeter of the outdoor area providing security and privacy. The garden areas are yet to be planted. There are plans for a sensory garden and edible plants for the psychogeriatric unit.

ARHSS D15.3d The "home" has its own lounge and dining area. There is an additional smaller lounge and seating alcove where quieter activities or family visits can take place. The lounge area is designed so that space and seating arrangements provide for individual and group activities.

ARHSS D15.3e: ARC D 15.3; The following equipment is available, electric beds, ultra-low beds, one standing hoist, one sling hoist, sensor mats, landing mats, pressure relieving mattresses, shower chairs, sliding sheets, walking frames, wheelchairs, tilting chairs, chair scales (calibrated August 2013). Interviews with one caregiver from the psychogeriatric unit confirmed there was adequate equipment. Staff interviewed in the hospital unit stated there is adequate equipment to deliver care as documented in the care plans.

ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required. Residents have the freedom to move between communal areas.

ARHSS D15.3b There is a safe and secure outside area that is easy to access.

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

All buildings, plant, and equipment comply with legislation.

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

Criterion 1.4.2.4 (HDS(C)S.2008:1.4.2.4)

The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.

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

Criterion 1.4.2.6 (HDS(C)S.2008:1.4.2.6)

Consumers are provided with safe and accessible external areas that meet their needs.

Attainment and Risk: FA
Evidence:
Finding:

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

Standard 1.4.3: Toilet, Shower, And Bathing Facilities (HDS(C)S.2008:1.4.3)

Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.

ARC E3.3d ARHSS D15.3c

Attainment and Risk: FA
Evidence: One hospital bedroom has an ensuite. All bedrooms are single in both units and have hand basins. There are adequate numbers of showers and toilets in each “home”. Fixtures, fittings and floor and wall surfaces are made of accepted materials for meeting hygiene and infection control practices and resident safety. Communal toilets and showers have occupied /vacant signs on the doors. Shower rooms have and privacy curtains. There are appropriately placed handrails in the bathrooms and toilets.

Criterion 1.4.3.1 (HDS(C)S.2008:1.4.3.1)

There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use.

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

Standard 1.4.4: Personal Space/Bed Areas (HDS(C)S.2008:1.4.4)

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.

ARC E3.3b; E3.3c ARHSS D15.2e; D16.6b.ii

Attainment and Risk: FA

Evidence:

Residents' rooms are of sufficient space to allow services to be provided and for the safe use, mobility aids and hoist if necessary. The bedrooms are personalised. The bedrooms environment is uncluttered. Electric beds or ultra-low beds are available for use. There is a mix of bedrooms with carpet and lino flooring.

Criterion 1.4.4.1 (HDS(C)S.2008:1.4.4.1)

Adequate space is provided to allow the consumer and service provider to move safely around their personal space/bed area. Consumers who use mobility aids shall be able to safely manoeuvre with the assistance of their aid within their personal space/bed area.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining (HDS(C)S.2008:1.4.5)

Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.

ARC E3.4b ARHSS D15.3d

Attainment and Risk: FA

Evidence:

Each "home", Haumaru and Aroha Nui, have spacious dining and lounge areas with access to the outdoor areas. There are other smaller areas and seating alcoves in each unit that are readily accessible to residents. Activities take place in the dining room or lounge area of each unit dependent on the type of activity. The small kitchenette wall in the psychogeriatric unit has been removed to open up the dining area into group or singular dining areas. Both dining spaces have outdoor access. ARHSS D15.3d: Seating and space is arranged to allow both individual and group activities to occur. D15.3d: Seating and space is arranged to allow both individual and group activities to occur.

Criterion 1.4.5.1 (HDS(C)S.2008:1.4.5.1)

Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.

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

Standard 1.4.6: Cleaning And Laundry Services (HDS(C)S.2008:1.4.6)

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.

ARC D15.2c; D15.2d; D19.2e ARHSS D15.2c; D15.2d; D19.2e

Attainment and Risk: FA
Evidence: <p>The service in place policies and procedures for effective management of cleaning and linen practices. The operations manager oversees the laundry and cleaning services. There is a housekeeper employed each day to carry out the laundry and cleaning duties. Caregivers assist with some duties such as ironing on the night shift. There is adequate washing and drying equipment to cope with the volume of laundry and personal clothing. There is a defined clean and soiled linen area. There is adequate linen stock sighted. There is a shared sluice and sanitizer located within the hospital unit. Protective equipment is available in the laundry and sluice room. Chemicals are stored safely in the laundry and cleaners trolley. Safety data sheets are available. Feedback on the service is received through internal audits, meetings and surveys. The chemical supplier completes regular audits on the laundry and cleaning practices, efficiency of equipment and effectiveness of chemical use. Families interviewed are very satisfied with the cleanliness of their relative's rooms and the care taken with personal clothing.</p>

Criterion 1.4.6.2 (HDS(C)S.2008:1.4.6.2)

The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.

Attainment and Risk: FA
Evidence:

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

Criterion 1.4.6.3 (HDS(C)S.2008:1.4.6.3)

Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment and chemicals.

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

Standard 1.4.7: Essential, Emergency, And Security Systems (HDS(C)S.2008:1.4.7)

Consumers receive an appropriate and timely response during emergency and security situations.

ARC D15.3e; D19.6 ARHSS D15.3i; D19.6

Attainment and Risk: FA
Evidence: <p>The service provides staff training to implement its policies and procedures for civil defence, equipment and other emergencies. Fire safety and evacuation training is provided to staff during their orientation phase and at appropriate intervals. The following training was provided in 2013; fire warden training, fire drills, and civil defence. There is an approved evacuation scheme (July 2003). There is someone on duty 24/7 with a current first aid certificate.</p> <p>D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Civil defence kit and water supply is in place and meets requirements.</p> <p>Resident rooms, toilets/showers and the lounge/dining areas have call bells. These also show up in other areas of the facility on panels. Emergency bells are heard throughout.</p> <p>The service policies and procedures require that contractors are appropriately identified and a contractor's folder is well established. Security policy is in place and a daily security check is documented.</p>

Criterion 1.4.7.1 (HDS(C)S.2008:1.4.7.1)

Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.

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

Criterion 1.4.7.3 (HDS(C)S.2008:1.4.7.3)

Where required by legislation there is an approved evacuation plan.

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

Criterion 1.4.7.4 (HDS(C)S.2008:1.4.7.4)

Alternative energy and utility sources are available in the event of the main supplies failing.

Attainment and Risk: FA
Evidence:

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

Criterion 1.4.7.5 (HDS(C)S.2008:1.4.7.5)

An appropriate 'call system' is available to summon assistance when required.

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

Criterion 1.4.7.6 (HDS(C)S.2008:1.4.7.6)

The organisation identifies and implements appropriate security arrangements relevant to the consumer group and the setting.

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

Standard 1.4.8: Natural Light, Ventilation, And Heating (HDS(C)S.2008:1.4.8)

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.

ARC D15.2f ARHSS D15.2g

Attainment and Risk: FA

Evidence:

General living areas and resident rooms are appropriately heated with corridor and bedrooms panel heaters. The panel heaters in the psychogeriatric unit have metal protective covers. Bedroom windows open safely. Family members interviewed state the home environment is comfortable. Residents have access to natural light in their rooms and there is adequate external light in communal areas.

Criterion 1.4.8.1 (HDS(C)S.2008:1.4.8.1)

Areas used by consumers and service providers are ventilated and heated appropriately.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 1.4.8.2 (HDS(C)S.2008:1.4.8.2)

All consumer-designated rooms (personal/living areas) have at least one external window of normal proportions to provide natural light.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

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

Outcome 2.1: Restraint Minimisation

Services demonstrate that the use of restraint is actively minimised.

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

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

Attainment and Risk: FA

Evidence:

The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention and it reviews past assistance / interventions. The service reviews the entire care plan monthly if a resident has restraint and this was documented well in the three restraint files reviewed. Suitably qualified and skilled staff in partnership with the family/whanau undertakes these. The RN / restraint coordinator is involved in the assessment process along with the family and GP. Care plans include a full description of the approved restraint intervention and monthly evaluation. The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence such as a lap belt in a wheelchair. There is also a policy for Enablers. There is one resident with an enabler. There are six residents on the register assessed as requiring intermittent restraint. One 'hand holding' and four resident with T belts and one resident with a low chair.

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

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

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Outcome 2.2: Safe Restraint Practice

Consumers receive services in a safe manner.

Standard 2.2.1: Restraint approval and processes (HDS(RMSP)S.2008:2.2.1)

Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The restraint coordinator is a registered nurse and experienced in dementia care. The restraint approval process and the conditions of restraint use are recorded on the "restraint risk assessment consent and management form". Consent for restraint use is logged in the restraint register. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP, in partnership with the resident (where able) and their family/ whanau. The multi-disciplinary team is involved in the assessment process.

Criterion 2.2.1.1 (HDS(RMSP)S.2008:2.2.1.1)

The responsibility for restraint process and approval is clearly defined and there are clear lines of accountability for restraint use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 2.2.2: Assessment (HDS(RMSP)S.2008:2.2.2)

Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

The service completes comprehensive assessments for residents who require appropriate restraint or enabler intervention. Suitably qualified and skilled staff in partnership with the family/whanau undertakes these. A restraint risk assessment, consent and management form is completed and signed by the resident representative (family / EPOA), RN, and GP and this was documented in the three restraint resident files reviewed.

Criterion 2.2.2.1 (HDS(RMSP)S.2008:2.2.2.1)

In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:

- (a) Any risks related to the use of restraint;
- (b) Any underlying causes for the relevant behaviour or condition if known;
- (c) Existing advance directives the consumer may have made;
- (d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;
- (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;
- (f) Maintaining culturally safe practice;
- (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);
- (h) Possible alternative intervention/strategies.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 2.2.3: Safe Restraint Use (HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: PA Low

Evidence:

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 were reviewed for residents with intermittent restraint. The review identified clear instructions for use of 'hand holding', approval process, risks and monitoring requirements.

The risk assessment, consent, and management form addresses criterion 2.2.3.2 and the restraint intervention is fully described in the care plan with daily monitoring records completed by staff. Most 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 30 minutes at a time. Restraint records show that this had been applied once for a period of two hours and this is an area requiring improvement.

The restraint register is in place and shows monthly evaluation. An updated register is completed each month and shows discontinued restraints.

Criterion 2.2.3.2 (HDS(RMSP)S.2008:2.2.3.2)

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:

- (a) Only as a last resort to maintain the safety of consumers, service providers or others;
- (b) Following appropriate planning and preparation;
- (c) By the most appropriate health professional;
- (d) When the environment is appropriate and safe for successful initiation;
- (e) When adequate resources are assembled to ensure safe initiation.

Attainment and Risk: PA Low

Evidence:

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 were reviewed for residents with intermittent restraint. The review identified clear instructions for use of 'hand holding', approval process, risks and monitoring requirements.

The risk assessment, consent, and management form addresses this criterion and the restraint intervention is fully described in the care plan with daily monitoring records completed by staff.

Finding:

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 30 minutes at a time. Restraint records show that this had been applied once for a period of two hours.

Corrective Action:

Ensure restraints are only applied for the duration for which they have been approved.

Timeframe (days): 90 (e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)

Criterion 2.2.3.4 (HDS(RMSP)S.2008:2.2.3.4)

Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:

- (a) Details of the reasons for initiating the restraint, including the desired outcome;
- (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;
- (c) Details of any advocacy/support offered, provided or facilitated;
- (d) The outcome of the restraint;
- (e) Any injury to any person as a result of the use of restraint;
- (f) Observations and monitoring of the consumer during the restraint;
- (g) Comments resulting from the evaluation of the restraint.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 2.2.3.5 (HDS(RMSP)S.2008:2.2.3.5)

A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 2.2.4: Evaluation (HDS(RMSP)S.2008:2.2.4)

Services evaluate all episodes of restraint.

ARC D5.4n ARHSS D5.4n, D16.6

Attainment and Risk: FA

Evidence:

Three files were reviewed of residents requiring intermittent restraint. The use of restraint episodes are evaluated in the care plan monthly and documented, if a change occurs it is documented at the time. All episodes are also reviewed by the restraint coordinator monthly and by the restraint committee.

Criterion 2.2.4.1 (HDS(RMSP)S.2008:2.2.4.1)

Each episode of restraint is evaluated in collaboration with the consumer and shall consider:

- (a) Future options to avoid the use of restraint;
- (b) Whether the consumer's service delivery plan (or crisis plan) was followed;
- (c) Any review or modification required to the consumer's service delivery plan (or crisis plan);
- (d) Whether the desired outcome was achieved;
- (e) Whether the restraint was the least restrictive option to achieve the desired outcome;
- (f) The duration of the restraint episode and whether this was for the least amount of time required;
- (g) The impact the restraint had on the consumer;
- (h) Whether appropriate advocacy/support was provided or facilitated;
- (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;
- (j) Whether the service's policies and procedures were followed;
- (k) Any suggested changes or additions required to the restraint education for service providers.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 2.2.4.2 (HDS(RMSP)S.2008:2.2.4.2)

Where an episode of restraint is ongoing the time intervals between evaluation processes should be determined by the nature and risk of the restraint being used and the needs of the consumers and/or family/whānau.

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

Standard 2.2.5: Restraint Monitoring and Quality Review (HDS(RMSP)S.2008:2.2.5)

Services demonstrate the monitoring and quality review of their use of restraint.

ARC 5,4n ARHSS D5.4n, D16.6

Attainment and Risk: FA
Evidence: The restraint coordinator is an experienced registered nurse. The restraint approval group at Millvale Levin includes (but not limited to) a family representative (interviewed), physiotherapist, GP, the safe transferring advisor, a diversional therapy representative, the management team and the education coordinator. An organisational report is completed around restraint use/training/incidents.

Criterion 2.2.5.1 (HDS(RMSP)S.2008:2.2.5.1)

Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:

- (a) The extent of restraint use and any trends;
- (b) The organisation's progress in reducing restraint;
- (c) Adverse outcomes;
- (d) Service provider compliance with policies and procedures;
- (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;
- (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;
- (g) Whether changes to policy, procedures, or guidelines are required; and
- (h) Whether there are additional education or training needs or changes required to existing education.

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

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

Standard 3.1: Infection control management (HDS(IPC)S.2008:3.1)

There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The infection programme is reviewed annually (November 2013), this was completed with ICNs across the organisations. The IC programme plan and IC programme description are available. There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the infection control committee at service and organisational level.

An established and implemented infection control programme is linked into the objectives of the quality and risk management plan for 2012-2013. The IC programme includes six objectives that include performance indicators and evaluation. The quality committee includes a cross section of staff from all areas of the service. The IC meeting at Millvale Levin meets monthly and at an organisational level six monthly. The facility has access to professional advice within the organisation, from GP's and from an IC consultant at the DHB.

The facility has adequate signage at the entrance asking visitors not to enter if they have contracted or been in contact with infectious diseases. Hand hygiene notices are in use around the facility. There is a staff health policy and staff infection and work restriction guidelines. There have been no identified outbreaks since previous audit. The outbreak management policy was recently amended to reflect current good practice with input from an IC consultant.

Criterion 3.1.1 (HDS(IPC)S.2008:3.1.1)

The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the organisation leading to the governing body and/or senior management.

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

Criterion 3.1.3 (HDS(IPC)S.2008:3.1.3)

The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.

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

Criterion 3.1.9 (HDS(IPC)S.2008:3.1.9)

Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.

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

Standard 3.2: Implementing the infection control programme (HDS(IPC)S.2008:3.2)

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA
Evidence: The monthly infection control committee meeting includes IC as an agenda item. The IC committee is made up of a cross section of staff from across the service. The service also has access to IC consultant, Public Health, GP's and the laboratory infection control team.

Criterion 3.2.1 (HDS(IPC)S.2008:3.2.1)

The infection control team/personnel and/or committee shall comprise, or have access to, persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.

Attainment and Risk: FA
Evidence:
Finding:
Corrective Action:

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

Standard 3.3: Policies and procedures (HDS(IPC)S.2008:3.3)

Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.

ARC D5.4e, D19.2a ARHSS D5.4e, D19.2a

Attainment and Risk: FA

Evidence:

The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff. Policy development involves the organisation IC nurses, the infection control committee and expertise from the regional clinical managers, quality and systems manager, and southern community laboratories. The manual included a list of amended policies.

D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff. Infection control programme includes infection control objectives as part of the quality and risk management plan. Policies include (but not limited to); a) hand hygiene, b) standard precautions c) transmission-based precautions, d) prevention and management of infection in staff, e) antimicrobial usage, f) pandemic planning, g) cleaning, disinfection, sterilisation, h) single use items, i) IC nurse duty schedule guidelines, j) IC education and staff training, k) IC education for residents and family.

The infection control manual is structured around four sections includes (but is not limited to):

Section 1: directors commitment/IC programme

Section 2: staff responsibilities for IC,

Section 3: IC policies and procedures

Section 4: Management of waste and hazardous materials.

Criterion 3.3.1 (HDS(IPC)S.2008:3.3.1)

There are written policies and procedures for the prevention and control of infection which comply with relevant legislation and current accepted good practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Standard 3.4: Education (HDS(IPC)S.2008:3.4)

The organisation provides relevant education on infection control to all service providers, support staff, and consumers.

ARC D5.4e ARHSS D5.4e

Attainment and Risk: FA

Evidence:

The infection control nurse is responsible for co-ordinating/providing education and training to staff and is supported by the clinical nurse manager. There are internal and external sessions available for training. The IC nurse has attended a DHB infection control study day and attends monthly IC training sessions at the DHB. Resident/family education is expected to occur as part of providing daily cares. Support plans can include ways to assist staff in ensuring this occurs. There is evidence of visitor education in the form of hand hygiene signs around the facility and at entranceways. There is policy around provision of infection control education for family members. Advised that the three monthly family newsletter and family meetings are an opportunity for management to include relevant infection prevention information.

Criterion 3.4.1 (HDS(IPC)S.2008:3.4.1)

Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.

Attainment and Risk: FA

Evidence:

Finding:

Corrective Action:

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

Criterion 3.4.5 (HDS(IPC)S.2008:3.4.5)

Consumer education occurs in a manner that recognises and meets the communication method, style, and preference of the consumer. Where applicable a record of this education should be kept.

Attainment and Risk: FA

Evidence:

Finding:

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

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

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

Attainment and Risk: FA

Evidence:

The infection surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The IC nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs (link 1.2.3.6). There is close liaison with the GP's and the laboratory infection control team who advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Infection control data is collated monthly and reported to the monthly infection control meeting. Infections are documented on the infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The IC programme is linked with the quality and risk management plan 2012-2013. The service benchmarks with other organisation owned services on a range of issues - infection control being one of them. Quarterly reports are also completed from benchmarking analysis. Monthly infection surveillance includes resident name, new/existing/acquired, type, symptom code, tests conducted, organism identified, treatment and whether resolved. Infection control surveillance outcomes are reported to all meetings and are included in the monthly staff bulletin. Analysis of trends is included in infection control meetings and an action plan established around good practice.

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

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

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

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

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

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