

Millvale Lodge Lindale Limited

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Millvale Lodge Lindale Limited
Premises audited:	Millvale Lodge Lindale
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 11 November 2014 End date: 12 November 2014
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	43

Executive summary of the audit




Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Dementia Care New Zealand – Millvale Lodge provides rest home, hospital, dementia care and psychogeriatric care for up to 47 residents. On the day of audit there were three rest home residents, 11 hospital residents, 13 dementia care residents and 16 psychogeriatric residents.

The operational manager (non-clinical and a qualified diversional therapist) has been in the role since April 2014. The clinical manager has been in the role since October 2014 and has had 20 years aged care experience.

The service provides a comprehensive orientation and training/support programme for their staff. Residents and relatives interviewed spoke positively about the care and support provided. Improvements are required around consents, aspects of interventions, staffing, standing orders, and fire evacuation plan approval by the fire service.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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There are policies for resident's rights that reinforces the Health and Disability Consumer Rights and staff received training around this. A review of care plans and meeting minutes confirmed that the service functions in a way that complies with the code of rights. Appropriate spiritual, religious, and cultural information was gathered on admission and care plans interventions included appropriate responding to the needs of residents. Residents and family members indicated that they were consulted in the identification of spiritual religious and or cultural beliefs. There are current guidelines for the provision of culturally safe care for Māori residents. Family/whanau involvement was actively encouraged through all stages of service delivery. Links were established with disability and other community representative groups as directed/requested by the resident/family/whanau. The organization provides an inter-cultural awareness education program for staff. Cultural safety is part of the orientation training and competency package. The complaints register was up to date and records the details of the complaint, date of corrective actions taken and signed off when resolved. Complaints were also linked to the quality management system. There is an improvement required around informed consents.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The operations manager of Millvale Lodge is responsible to the general manager and reports on a daily basis on a variety of issues relating to the strategic and quality plan. She is supported by the clinical manager who is an experienced registered nurse with 19 years in aged care. The service has an established quality and risk management system. The quality program is managed by the operations manager and the quality and systems manager for the organization. There were a number of quality initiatives completed since the opening of the service, these include feedback from the family members with post six monthly surveys, complaints management system, audit results and staff and quality meetings.

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

Human resource policies and procedures were implemented. There is a comprehensive orientation program that provides new staff with relevant information for safe work practice.

Staff completed “Best Friends Approach to Dementia Care” training program and “Non Violent Crisis Intervention training”. These are offered to all staff several times during the year. Dementia care NZ had established a clinical governance group within the company. In 2014 several quality issues were reviewed by the group such as outbreak management, registered nurse professional development program and workforce development with carers.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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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, dementia care and psychogeriatric level) and practices particular to the secure units. Care plans are developed by registered nurses and are reviewed 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 an improvement required around interventions. A 24 hour

multidisciplinary care plan identifies a 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. All staff are qualified in their roles and complete on-going training around clinical requirements and the specific needs of people with advanced dementia and challenging behaviours. The service has access to a Wellness Support resource person. There is a two monthly resident review by the medical practitioner, geriatrician and psychogeriatrician.

The activity team develop a programme to meet the recreational needs and preferences of each consumer group. There is a flexible and resident focused activity plan over seven days a week in the psychogeriatric unit, dementia care and rest home/hospital 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 programme in place. The GP reviews the resident's medication at least three monthly. There is an improvement required around the standing order format.

The service has contracted to work with a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files. The menu is reviewed by the organisational dietitian.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. Equipment purchased is less than a year old. The service has an equipment preventative maintenance programme in place to ensure that

buildings, plant, and equipment are maintained appropriately. There is a certificate for public use in place. The building has a residential area which is fully completed. The office area which includes several offices, staff room, laundry, kitchen and the training room has not been fully completed yet.


Millvale Lodge provides rest home/hospital, dementia care 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 has easy access to their external gardens and paths. Residents in the dementia and psychogeriatric “homes” are able to move freely inside and within their separate secure environments.

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 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.

there are emergency management plans in place to ensure health, civil defence and other emergencies are included. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. Required corrective action from the previous audit around approval of fire evacuation scheme from the NZ Fire Service has not been addressed yet.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There are policies around restraint, enablers and the management of challenging behaviours. Millvale Lodge is using restraint in a form of hand holding restraint, a T-belt restraint and bed rails. There are no residents at Millvale Lodge with enablers. The restraint

coordinator is the clinical manager. The restraint approval process and the conditions of restraint use was recorded. The multi-disciplinary team is involved in the assessment process. Staff have completed restraint minimization training and competency assessments. Restraint has been used intermittently and monitoring of restraint use occurs. Prior to use of restraint appropriate alternative interventions have been implemented and family discussions were documented and approval was obtained. Behaviour charts were completed and used to identify triggers. The restraint monitoring and quality review occurs.

Infection prevention and control

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	5	0	0	0
Criteria	0	95	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>There are policies for resident's rights that reinforces the Health and Disability Consumer Rights (Code of rights). Discussion with staff (five care givers, one registered nurse (RN), and a diversional therapist) indicates that all were aware of the Code of Rights and could describe the key principles. Staff received training around the Code of Rights and this was also included in the orientation training session. A competency package was completed by staff. Staff observed treating residents with respect and feedback from resident (one hospital and rest home) and family interviews (one hospital, one psychogeriatric and four dementia) were all positive.</p> <p>A review of care plans and meeting minutes (including resident meeting) confirmed that the service functions in a way that complies with the code of rights.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	PA Low	<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</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>and social display and consent for outings. Residents have a medical guidance plan that covers admission to hospital and resuscitation. There is evidence of enduring power of attorney (EPOA), general practitioner and clinical manager participation in the medical guidance plan. Medically indicated not for resuscitation status evidences discussion with the EPOA/family. The GP or specialists has completed letter of mental capacity for residents where appropriate. Mil vales 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> <p>General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings.</p> <p>There is evidence of enduring power of attorney (EPOA), general practitioner and clinical manager participation in the medical guidance plan.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There is a policy around advocacy services. Residents' rights to access advocacy services is identified, and located in the entrance foyer. Advocacy information provided at the time of entry to residents and family/whānau. Staff interviewed (five caregivers and one RN) were very aware of the right for advocacy and how to access and provide advocate information to residents if needed. Advocacy training was provided to staff.</p> <p>ARHSS D4.1f: Resident files included information on resident's family/whanau and chosen social networks</p> <p>D4.1d; Discussion with family members (one hospital, one psychogeriatric and four dementia) identified that the service provides opportunities for the family/EPOA to be involved in decisions and they were aware of their access to advocacy services.</p>

<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Links with the family /whanau and the other community resources has been established. There is a policy for maintaining links within the community. Staff and management interview confirmed that community services and groups were encouraged to support and visit residents. Church services occur monthly.</p> <p>ARHSS D16.5f: Discussion with family members (one hospital, one psychogeriatric and four dementia) confirmed that they were encouraged to be involved with the service and care of the residents. Visiting was actively encouraged. Millvale Lodge has open visiting hours.</p> <p>D3.1.e The facility activity program encourages links with the community. Activities program include opportunities to attend events outside of the facility including activities of daily living such as shopping. Entertainers were included in the activities program.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Complaints information was provided at entry to the service and is readily available to residents and complies with right 10 of the Code. Residents/family/whanau were supported to discuss the complaint process.</p> <p>The complaints register was up to date and recorded the details of the complaint date of corrective actions taken and signed off when resolved. A complaints folder contained all documentation for the complaints received since the opening of the service. Complaints were discussed at the quality management meetings, at organizational level and at the staff meetings. Complaints were also linked to the quality management system and several improvements to the service have occurred. Such as review of the infection control practices and improvements in the food services.</p> <p>D13.3h. a complaints procedure was provided to residents within the information pack at entry.</p> <p>ARHSS D13.3g: The complaints procedure was provided to relatives on admission.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Millvale Lodge has an information booklet which includes the Code of Rights and advocacy information.</p> <p>The Code of Rights and advocacy information and pamphlets are displayed on entrance to the service. Information provided at the time of entry and provides residents and family/whānau with advocacy information. Staff is aware of the right for advocacy and how to access and provide advocate information to residents if needed.</p> <p>Family (six) and staff interviews (five caregivers and one RN) confirmed that the Code of Rights and accesses to advocacy services was discussed at the entry to the service.</p> <p>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.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Millvale Lodge has policy and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code.</p> <p>Staff can describe the procedures for maintaining confidentiality of resident information and employment agreements bind staff to retaining confidentiality of resident information.</p> <p>Appropriate spiritual, religious, and cultural information was gathered on admission and care plans interventions include appropriate responding to the needs of residents.</p> <p>Residents (two) and family members (six) indicated that they are consulted (involved) in the identification of spiritual religious and or cultural beliefs. Discussions with five caregivers and an RN described the importance of accessing values and beliefs from resident families during the admission and the ongoing involvement of families.</p> <p>Resident preferences were identified during the care planning process. There is a variety of activities and residents choose whether to be involved. Personal freedom is promoted, within the resident's ability. There is a link with recreation and the care plan. Involvement of family in</p>

		<p>all stages of service delivery ensures resident wishes are considered and documented. The care plan is goal focused and progress to meeting the goals is documented.</p> <p>There is an abuse and neglect policy that includes definitions and examples of abuse. Discussion with five caregivers across all service areas identified that they were all aware of the requirements and indicators around elder abuse. Staff received training around elder abuse.</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>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	<p>FA</p>	<p>There are current guidelines for the provision of culturally safe care for Māori residents. There was one Maori resident in Millvale Lodge on the day of audit. Review of this file showed that the care plan interventions included Maori cultural needs and extended whanau involvement. Care planning process was completed in conjunction with the resident/whanau.</p> <p>Discussions with an RN, clinical manager, operations manager and five caregivers indicate that they have an awareness of the need to respond appropriately to the cultural values and beliefs of Māori. Family/whanau involvement is actively encouraged through all stages of service delivery. Links were established with disability and other community representative groups as directed/requested by the resident/family/whanau.</p> <p>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)</p> <p>D20.1i The service has established a local contact that is Māori and is available for advice as required.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Information on values and beliefs was gathered on admission with family involvement and was integrated with the residents care plans. The assessment process and philosophy of care enables appropriate responses to individual cultural beliefs. This includes cultural, religious, social and ethnic needs. Staff interview (five caregivers and one RN) confirmed that staff recognize and respond to values, beliefs and cultural differences. Family interviews (one hospital, one psychogeriatric and four dementia) confirmed that they were involved with the care planning, initially on admission and then three weeks after admission they reviewed the long term care plan.</p> <p>D3.1g The service provides a culturally safe service by implementing the organization'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.</p> <p>ARHSS D4.1d: Care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p> <p>The organization provides an inter-cultural awareness education program for staff. Cultural safety is part of the orientation training and competency package.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>There are policies and procedures that include abuse and neglect professional boundaries, code of rights, complaints, values and beliefs, sexuality and house rules. These topics were included in the annual training program. Discussion with the operations manager and a review of complaints identified no complaints of discrimination, coercion or exploitation of residents. Job descriptions include responsibilities of the position. Staff interviewed were aware of and alert to the potential for racial and sexual harassment. Performance appraisals were conducted. Staff and management interviews reinforced professional boundaries.</p> <p>ARHSS D16.5e: Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with five caregivers could describe how they build a supportive relationship with each resident. Interviews with family members (one hospital, one psychogeriatric and four dementia) confirmed the staff</p>

		assist to relieve anxiety.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Millvale Lodge implements its policies, quality / risk system, care planning and staff training program to meet the needs of residents for both rest home, hospital and specialized dementia care. A thorough staff training program and completion of dementia specific training supports the service in meeting the needs of residents.</p> <p>A quality monitoring program was 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, education and competencies, complaints and incident management.</p> <p>There is an internal audit schedule that is fully implemented.</p> <p>There are a number of new initiatives at Millvale Lodge. A Wellness Support Advisor has been employed to provide support to the diversional therapy team. A role of two Regional Clinical Managers (North Island and South Island) have been developed to lead and provide guidance to the clinical managers. They have facilitated a mentoring of staff by more senior members of the team. Both Clinical Manager and the Operations Manager have attended organizational training days. A clinical supervision process is available for all RNs.</p> <p>Regular "Best Friends Approach to Dementia Care" training was carried out for all staff and this is key to living their values and philosophy. Non Violent Crisis Intervention training is on-going for staff and inter-cultural Awareness training has commenced.</p> <p>Dementia Care NZ has developed a new Business plan that includes three governance groups. These are clinical, operational and executive governance. The new business plan aims to link with the national projects.</p> <p>There is an internal benchmarking system to assist in identifying trends and for future planning of services. An extensive annual program of staff training occurs including a number of external speakers. Six week post admission surveys were completed and these were linked to the quality</p>

		<p>improvement system.</p> <p>A2.2 Services are provided that adhere to the health & disability services standards. There is an implemented quality improvement program that includes performance monitoring.</p> <p>D1.3 all approved service standards are adhered to.</p> <p>D17.7c There are implemented competencies for all staff including caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy that include information on residents or their representative have the right to full and open disclosure. Incident and accident forms were completed by either caregivers or RNs and a copy of any incident relating to individual residents was included in the clinical file. The incident forms recorded that families or next of kin were informed following incidents or accidents or if there is a change in resident condition. Family interview (one hospital, one psychogeriatric and four dementia) confirmed this. Resident's progress notes also includes family notification. This was confirmed through the clinical files reviewed. Complains were followed up and feedback given to the complainant.</p> <p>There is an interpreter policy in place with information included in the admission booklet.</p> <p>D12.1 Non-Subsidised residents are advised of the process and eligibility to become a subsidized resident through the admission booklet.</p> <p>D16.4b Residents (one hospital and one rest home) and families (six) interviewed confirmed they are kept fully informed.</p> <p>D11.3 The admission booklet is available in large print and can be read to residents if required.</p> <p>ARHSS D16.1bii; 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</p>

		residents and their families.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Dementia Care NZ Ltd is the parent company and operates Millvale Lodge Lindale limited. Dementia Care NZ 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 organization to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organization.</p> <p>The purpose, values, scope, direction, and goals of the organization are clearly identified in the business plan 2014-2015.</p> <p>Millvale Lodge provides care for up to 47 residents and occupancy on the day of audit was at 43. There are three homes. Nikau Home has 16 beds that provides dual services. There were three rest home residents and 11 hospital (medical and geriatric) residents. Toe Toe Home two has 15 residents that required dementia level care and the occupancy was 13. Tanika Home has 16 psychogeriatric beds and the occupancy was at full capacity.</p> <p>The operations manager of Millvale Lodge is responsible to the general manager and reports on a daily basis on a variety of issues relating to the strategic and quality plan. She has been with the company for several years and she is a qualified diversional therapist. The clinical manager is an experienced RN with 19 years in aged care. She has a post graduate certificate in Gerontology- Clinical Nursing from Victoria University of Wellington – 2007. She was recently appointed to this role.</p> <p>The service has an established quality and risk management system. The quality program is managed by the operations manager and the quality and systems manager for the organization.</p> <p>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 minimizes risks associated with their confused states.</p> <p>ARHSS D17.5 The manager has maintained at least eight hours annually of professional development activities related to managing a hospital.</p>

<p>Standard 1.2.2: Service Management</p> <p>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.</p>	<p>FA</p>	<p>During a temporary absence of the operations manager, the facility is managed by the clinical manager. Discussions with the general manager confirmed that depending on the length of the leave Dementia Care NZ team may place in a temporary manager and the current team is supported by the sister company Millvale House Waikanae. At an organizational level, there is a North Island regional clinical manager that provides clinical support and leadership.</p> <p>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.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Millvale Lodge has a strategic business plan and a quality and risk management plan that are implemented and managed at service level by the operations manager. Staff interview (five caregivers, one RN, one clinical manager) confirmed that all staff are involved in implementation of the quality system.</p> <p>A range of quality data was collated, analysed and evaluated including infections summary/surveillance, incidents, complaints, surveys, restraint register and internal audits. Internal benchmarking occurs with other services under Dementia Care N.Z.. Quality results were communicated to staff meetings /quality meetings. Quality improvements are raised where there is an identified short fall in internal audit outcomes and other parts of the quality management system.</p> <p>Monthly meetings occur to implement the quality / risk system. All areas of the service included in the audit schedule and re-audits were completed when a non -compliance was identified.</p> <p>The health and safety policies were implemented. This was evidenced in a review of monthly meeting minutes. Dementia specific procedures were in place for managing challenging behaviours, restraint minimization and de-escalation.</p> <p>Infection control data was collated monthly and reported to the monthly infection control committee meetings and the quality committee meetings.</p>

		<p>Actual and potential risks were identified and corrective actions were initiated. This was discussed at the monthly quality meetings, monthly health and safety meetings and reported to the directors/proprietors in the operations manager's monthly report. There is a hazard identification register that includes type, potential harm, action to minimize, control measures and checks. The hazard register was reviewed annually.</p> <p>Restraint was reviewed at the monthly quality meetings and six monthly restraint approval committee.</p> <p>D19.3 there are implemented risk management, and health and safety policies and procedures in place including accident and hazard management</p> <p>D19.2g Falls prevention strategies include policies for falls prevention and interventions such as; falls risk assessment on admission and re-evaluation, at risk of falling into care plan, environment, elimination and mobility. Falls prevention is also identified as high priority goals in the 2014-2015 Business plan.</p> <p>Families interviewed (one hospital, one psychogeriatric and four dementia) confirmed the range of feedback and support around understanding of dementia. One family member interviewed stated that she had participated in a training session in Millvale Lodge around dementia care and this assisted her on how to react and comfort her mother in difficult times.</p> <p>There are a number of quality initiatives completed since the opening of the service. These include feedback from the family members in post admission six monthly surveys, complaints management system, audits results and staff and quality meetings.</p> <p>There is an annual staff training program that is implemented and based around policies and procedures.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open</p>	<p>FA</p>	<p>Incident/accidents were documented; reporting of incidents occurs and were monitored with action taken on trends to improve service delivery. There is an electronic incident and accident register and completed incidents /accident forms were kept on the resident's files. The information on incident and accidents were also recorded in the progress</p>

<p>manner.</p>		<p>notes. Incident analysis was completed monthly and it breaks down to the areas in the service rest home and hospital, dementia and psychogeriatric unit. Incidents and accidents were linked to the quality and risk management system and the care plan interventions. This was evidenced in review of the quality data and the resident's care plan interventions.</p> <p>D19.3d the service is aware that they will inform the DHB of any serious accidents or incidents. Discussions with the operations manager and clinical nurse manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource policies and procedures are implemented. Performance appraisals were up to date for staff who were transferred from the parent companies and new staff who were not due yet. A copy of practicing certificates has been sighted for all current RNs.</p> <p>There is a comprehensive orientation program that provides new staff with relevant information for safe work practice. Files reviewed evidenced that RNs and caregivers had completed the orientation program.</p> <p>D17.8.The annual training program well exceeds eight hours annually.</p> <p>Staff completed "Best Friends Approach to Dementia Care" training program and "Non Violent Crisis Intervention training". These are offered to all staff several times during the year.</p> <p>ARHSS D17.1: E4.5f. Millvale Lodge employs 30 caregivers. 15 caregivers have completed required dementia standards and the remaining 15 caregivers have already commenced the dementia standards and aim to complete these within 12 months.</p> <p>There is an education coordinator employed to oversee the organization's education program for all homes and is available to facilitate sessions. The education coordinator manages a spread sheet of all staff and records all completed orientations, competencies and education attended.</p>

		<p>Discussions with the management confirmed that all management team members had completed clinical supervision training which included receiving and giving clinical supervision. Clinical supervision is offered to all registered nurses.</p> <p>Dementia care NZ had established a clinical governance group within the company. In 2014 several quality issues were reviewed by the group such as outbreak management, RN professional development program and workforce development with carers.</p> <p>Dementia care NZ has also developed a role for two regional clinical managers (one for the North Island and one for the South Island). The main purpose of these roles is to lead and provide guidance to the clinical managers.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Low</p>	<p>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 three units. There is a registered nurse on duty in the unit 24/7. Operations Manager – Monday to Friday.</p> <p>Clinical manager – Monday to Friday</p> <p>1x Registered Nurse on duty over 24 hours a day. – Located in the psychogeriatric wing.</p> <p>1x DT 10am - 12.30pm covering all areas</p> <p>Hospital wing – Nikau- 16 bed capacity</p> <p>AM - 2x caregiver -7am to 3 pm, 1x caregiver -8-1 pm, DT – 1pm- 4.30 pm</p> <p>PM- 1x caregiver 3pm to 12 pm, 1x caregiver 3pm- 9 pm , 1xcaregiver 4.30 -8 pm. Nocte 1x caregiver -12 pm-8 am</p> <p>Dementia wing – Toe Toe- 15 bed capacity</p> <p>AM - 2x caregiver -7am to 3 pm , 1x caregiver -8-1 pm, DT – 1pm- 4.30 pm</p> <p>PM -1x caregiver 3pm to 12 pm, 1x caregiver 3pm- 10 pm , 1xcaregiver</p>

		<p>4.30 -8 pm. Nocte 1x caregiver -12 pm- 8 am</p> <p>Psychogeriatric wing - Tanika 16 bed capacity</p> <p>AM - 2x caregiver -7am to 3 pm , 1x caregiver -8-1 pm, DT – 1pm- 4.30 pm</p> <p>PM -1x caregiver 3pm to 12 pm, 1x caregiver 3pm- 10 pm , 1xcaregiver 4.30 -8 pm. Nocte 1x caregiver -12 pm 8 am.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>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 unauthorized access. Resident records were kept up to date and reflect residents' current overall health and care status. Records can be accessed appropriately by staff.</p> <p>D7.1 Entries were legible, dated and signed by the relevant staff member including designation. Individual resident files demonstrate service integration. Medication charts were in a separate folder.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are pre-entry and admission procedures in place. Residents are assessed on entry to the service and needs assessments are sighted on the seven (two hospital, one rest home, two psychogeriatric and two dementia care) resident files sampled. The service liaises with assessment services and service coordinators as required. The service has a good relationship with the assessors and services for the older person. The service maintains good relationships with groups such as Alzheimer's Society. 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. The service has implemented "Orientation for Families" a three week course and "Sharing the Journey" a four week course for families to assist them with coming to terms with a resident with advanced dementia and provides education, care and support for the family. Six family (one hospital, one psychogeriatric and four dementia care) members interviewed state they received sufficient</p>

		<p>information on the services provided and are appreciative of the staff support during the admission process.</p> <p>D13.3 the admission agreements reviewed (one rest home. two hospital, two psychogeriatric and two dementia care) aligns with a) -k) of the ARC contract.</p> <p>D14.1 Exclusions from the service are included in the admission agreement.</p> <p>D14.2 the information provided at entry includes examples of how services can be accessed that are not included in the agreement.</p> <p>E4.1.b There is written information on the service philosophy and practices particular to the Unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other Residents are managed and c) specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none"> 1. Minimising restraint. 2. Behaviour management. 3. Complaint policy. <p>E3.1 Two files reviewed include a needs assessment as requiring specialist dementia care.</p> <p>Two psychogeriatric resident files reviewed had needs assessments approved by the psychogeriatrician.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is a Discharge Planning and Transfer Policy and Resident Transfer to Hospital (Acute) policies to guide staff in this process. Discussions with the service confirm that resident exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of residents care through the completed internal transfer form, copy of relevant progress notes, copy of medication chart and doctor's notes. The service use the district health board (DHB) "Yellow" envelope system. A staff member or family member (as appropriate) accompanies the resident to the hospital.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The medication management system includes Medication Policy and Procedures that follow 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.</p> <p>The service uses robotic system for regular and prn medications. The RN checks these on arrival and signs the medication checking form. Medication reconciliation is implemented via the 'Medication Management on Admission and Transfer policy'. RNs administer medications in the hospital and psychogeriatric units. Senior caregivers administer medications in the rest home. Orientation to medications include a self-learning package and supervised medication rounds. All those administering medications have completed competency and education. Staff are not yet due for their annual review. Liverpool care pathway (LCP) is in place for end of life/palliative care. RNs have completed syringe driver education and refreshers. LCP medications are held in controlled drug safe in the hospital unit. There is a main locked medication room in the hospital/rest home where all pharmaceuticals are kept. Medication trolleys for the dementia care and psychogeriatric "homes" are kept in a locked area. Controlled drugs are kept in a controlled drug safe in the hospital. There are weekly controlled drug checks (sighted) recorded in the controlled drug register. The supplying pharmacy completes six monthly audits. Medication fridge temperatures are monitored daily. The medication folder contains specimen signature list, 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). All eye drops in the medication trolley are dated on opening. Returns to the pharmacy are kept in the locked medication room until returned. There are no self-medicating residents at the facility. All signing sheets are correct and</p>

		<p>correspond with the instructions on the medication chart. PRN medications have the date and time of administration on the signing sheet. Two staff sign for the administration of controlled drugs.</p> <p>The medication charts are computer generated by the pharmacy and are reviewed at least three monthly. All medication charts had current (dated) photo identification and allergies noted. Special medication instructions and precautionary advice is recorded on the medication charts.</p> <p>D16.5.e.i.2; 14 medication charts reviewed (two rest home, four hospital, four dementia care and four psychogeriatric) identified that the GP had seen the resident 3 monthly and the medication chart was reviewed and signed..</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<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 until 5pm to prepare, cook and serve the meals. An afternoon kitchen hand assists the cook with the evening meal which is the main meal of the day. There is an organisational dietitian contracted to review the menus two yearly. Special diets are incorporated into the menu. The RN completes a food and nutrition information form on each resident. A copy is received by the cook. The cook is notified of any dietary changes/requirements. The contracted dietitian for the facility undertakes a nutrition and dietetic assessment for each resident on admission and visits the facility monthly. All meals are prepared in the main kitchen and transported in bain marie containers to the individual units kitchenettes for serving by the care staff. Hot food temperatures and serving temperatures are monitored daily. Resident likes and dislikes are known and alternative foods are offered. Cultural and spiritual needs are met. Special diets are provided such as vegetarian, diabetic desserts and pureed food. Lip plates and specialised utensils are available as needed to promote independence at meal times. All food in the chiller, freezers and fridges are dated. There is daily fridge and freezer temperature monitoring. There are additional nutritional snacks available for residents and staff have open access to the kitchen.</p>

		<p>The new kitchen is well equipped with gas and electric cooking and new appliances in place. Fly screens are in place over the windows. There is a cleaning schedule maintained. Goods are checked on delivery. The cook is observed wearing appropriate personal protective clothing. Chemicals are stored safely within the kitchen.</p> <p>The kitchen staff have attended food safety and hygiene, chemical safety and relevant in-service offered on-site. Care staff have completed food safety and hygiene competencies.</p> <p>ARHSS D15.2f: E3.3f; There is evidence that additional nutritious snacks are available over 24 hours. Finger foods, sandwiches, cakes, protein drinks and deserts are sighted available in the "home" kitchen fridge.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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.</p>	FA	<p>The reason for declining service entry to residents is recorded should this occur and communicated to the resident/family/whanau. The clinical manager (CM) stated the referring agency would be advised when a resident is declined access to the service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>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.</p> <p>A range of assessment tools are completed on admission and reviewed at least three to six 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, 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 – My Profile. Assessments are conducted at the facility in agreement with the resident/family member or EPOA. Residents have private rooms where they can be assessed.</p>

		<p>ARHSS D16.5gii Two resident files sampled included an individual assessment that included identifying diversional, motivation and recreational requirements over the 24 hour period.</p> <p>E4.2; Two dementia resident files reviewed included an individual assessment (specific dementia needs) that included identifying diversional, motivation and recreational requirements over the 24 hour period.</p> <p>E4.2a: Challenging behaviour charts and behaviour monitoring is completed where required, and as a result, de-escalation strategies have been included in the long term care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans are developed and reviewed by the RN's. The long term care plan is developed within three weeks of admission in all seven files sampled. The care plan plans are comprehensive and meets residents needs and includes diagnosis/needs, aim and action. The long term care plan includes the resident details, medical problems, any special needs and identifies 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. A 24 hour MDT (multidisciplinary) care plan is completed by the DT and RN. The MDT care plan details the residents morning, afternoon and night habits, behaviours, activities or diversions that work, 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. 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) long term care plan and 24 hour care plan , h) activities plan, i) short term care plans, j) progress notes, k) incident forms. l) All assessments, m) allied health input, n) GP and other medical notes, o) lab results, p) correspondence.</p> <p>ARHSS 16.3g: Two psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific</p>

		<p>behavioural management strategies. The two residents had comprehensive behaviour management plans, behaviour charts and behaviour monitoring as applicable.</p> <p>D16.3k, Short-term care plans are used for short term needs. Short term care plans sighted are for falls, skin tear and urinary infection.</p> <p>D16.3f; Seven resident files reviewed identified that family are involved in care planning. Relatives interviewed (one hospital, four dementia care and one psychogeriatric) confirm they are involved in the care planning process.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<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 (one hospital, four dementia care and one psychogeriatric) and two residents (one rest home and one hospital) state resident needs are being met.</p> <p>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.</p> <p>There are wound assessment plans and wound dressing schedules for two skin tears and one pressure area of the heel that is almost healed. The GP and family were notified of the pressure area and there is documentation linked to the long term care plan. Photos have been taken to monitor progress. Currently there are three skin tears, two minor wounds and one head laceration in the psychogeriatric unit. There are no residents with skin tears or wounds in the dementia care unit.</p> <p>Specialist wound and continence management advice is available as needed through the organisation specialists. Adequate dressing supplies and continence products are sighted.</p> <p>Continence assessments including a urinary and bowel continence assessment are completed on admission and reviewed three/six monthly.</p>

		<p>Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained.</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 (Abbey) 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> <p>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 are sighted in the resident files sampled.</p> <p>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.</p> <p>Challenging behaviour assessments are well documented with follow up into care plans. Behaviour monitoring forms are used to record behavioural or disruptive actions and describe distraction techniques.</p> <p>ARHSS D16.4; There is good specialist input into residents in the psychogeriatric unit. Strategies for the provisions of a low stimulus environment could be described by the care team and diversional therapist.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The company Diversional Therapy (DT) team leader/Wellness Support resource person is available for 20 hours a week to support the diversional therapy team. The facility employs a full-time fully trained DT. She provides diversional therapy in all homes from 10am to 12.30pm They are actively recruiting for a part-time activities person and a fulltime</p>

	<p>activity person to cover parental leave. Two part-time caregivers and the diversional therapist currently provide activities three hours an afternoon in each of the hospital/rest home, dementia care and psychogeriatric “homes”. The activity programme is delivered seven days a week for all levels of care.</p> <p>The hours and timing of activities in the dementia care and psychogeriatric “homes” are monitored to ensure the programme is best suited to the resident needs. Varying activities occur simultaneously in both the units and are focused on sensory activities and reflect on daily activities of living such as music, poetry, craft, reminiscing, board games, garden walks, café club and baking. Residents are invited to attend entertainment held in the rest home/hospital “home”.</p> <p>The rest home/hospital programme reflects resident interests, abilities and skills and includes entertainment, exercises, creative activities, happy hour, news and views.</p> <p>Residents are encouraged to maintain community links such as stroke club, coffee clubs, church groups and community events. There are two volunteers involved in the activity programme. Residents who are unable to participate or choose not to have one on one time spent with them including pampering, reading and discussions.</p> <p>Church services are held every Wednesday and Sunday. Community church and youth groups visit.</p> <p>There is a monthly theme that is incorporated into the activity programme and festive occasions and events are celebrated. Resident outings are offered. There is a shared wheelchair van for outings. The DTs team have first aid certificates.</p> <p>Activity assessments, activity plan, 24 hour MDT plan, progress notes and attendance charts are maintained. The DT liaises with the family and resident as appropriate to develop the Tree of Life. Resident meetings are held monthly. There are regular MDT family meetings.</p> <p>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 three monthly.</p>
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<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Nursing care plans are reviewed by the MDT three monthly (hospital level) and six monthly (rest home level) or earlier due to health changes. The MDT include the nursing and care staff, DT, GP, physio, family/whanau/EPOA as appropriate and evidenced in the MDT meeting minutes. A written evaluation indicates if the resident goals have been met or unmet. Other health professionals are involved as appropriate. Short-term care plans are reviewed as required and are resolved or if an ongoing problem added to the long term care plan. There is at least a three monthly review by the medical practitioner of the resident and their medications. On-going nursing evaluations occur daily/as indicated and are included within the progress notes.</p> <p>The three/six monthly written review covers resident recordings (weight, blood pressure, and pulse), physical examination, restraint (if applicable), behaviour, family discussions, medication review and falls (if relevant).</p> <p>ARHSS D16.3c: Initial care plans of the two resident files sampled have been evaluated by the RN within three weeks of admission.</p> <p>D16.4a Care plans are evaluated six monthly more frequently when clinically indicated.</p> <p>ARC: D16.3c: Initial care plans of the one rest home and two hospital residents have been evaluated by the RN within three weeks of admission.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs referral documentation is maintained (link 1.3.6.1). There is good communication with the GP's, mental health</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>for the older person's team and the psychogeriatric services. Family/whanau/EPOA are involved as appropriate when referral to another service occurs. Referrals sighted in the resident files sampled include; older adult community psychiatric nurse, psychiatry services, geriatrician, palliative care services, physiotherapist, dietitian, haematology and podiatrist.</p> <p>D16.4c; the service liaises closely with the needs assessment team, geriatrician, psychogeriatric and mental health team. Currently there is one psychogeriatric resident who has been referred for a review of level of care to hospital care.</p> <p>D 20.1 discussions with registered nurses identified that the service has access to dietitian, physiotherapy, speech language therapist, wound care and continence specialist, podiatrist and mental health nurses and practitioners, hospice nurses and specialists.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<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. Chemicals are labelled correctly and stored safely throughout the facility. Staff are observed wearing protective equipment and clothing carrying out their duties. Gloves, aprons and face shields are available for staff in the sluice rooms, cleaners and laundry room. Staff have attended chemical safety training. The chemical supplier provides safety data sheets, product use information and conducts quality control checks on the effectiveness of chemicals. Approved containers are used for the safe disposal of sharps. Staff interviewed were able to describe waste management and chemical safety procedures.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	<p>FA</p>	<p>Millvale Lodge is currently operating under a certificate for public use (CPU) that expires 2 March 2015. The new purpose built facility is divided into three "homes" which are Nikau (16 rest home/hospital beds),</p>

<p>environment and facilities that are fit for their purpose.</p>	<p>Tanika (16 bed psychogeriatric) and Toe Toe (15 bed dementia care beds). The training room is yet to be completed. The three “homes” are spacious with wide corridors that allow for the use of mobility equipment.</p> <p>A maintenance person is employed full time and covers three Dementia Care New Zealand facilities within the region. 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 carry out larger repairs and they are available 24/7 for essential services. The maintenance person reports to the owner/director.</p> <p>Electrical equipment has been purchased new and not due for the annual electrical fitness check. Clinical equipment has been purchased new and not due for annual service/calibration. There is a monthly planned maintenance schedule that includes resident mobility equipment.</p> <p>Each “home” has its separate outdoor deck and garden area with safe access. There is seating and shade is provided over the summer months. A children’s playground is available for visiting families. There is a rural outlook from each “home”</p> <p>ARHSS D15.3d; ARC D 15.3; Each “home “has its own lounge, kitchenette and dining area. There are additional smaller lounges and seating alcoves where quieter activities or family visits can take place. The lounge areas are designed so that space and seating arrangements provide for individual and group activities.</p> <p>ARHSS D15.3e: ARC D 15.3; The following equipment is available, electric beds, ultra-low beds, two standing hoist, two sling hoist, sensor mats (10), landing mats, pressure relieving mattresses, shower chairs, slidy sheets, walking frames, wheelchairs, hospital lounge chairs and chair scales (purchased less than year ago) . Interviews with five caregivers from across the three levels of care confirmed there was adequate equipment to safely deliver care as documented in the care plans.</p> <p>ARHSS D15.2e: There are quiet, low stimulus areas that provide privacy when required. Residents have the freedom to move between communal areas.</p> <p>ARHSS D15.3b There is a safe and secure outside area that is easy to</p>
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		<p>access.</p> <p>E3.4d, There is an open plan lounge area designed so that space and seating arrangements provide for individual and group activities.</p> <p>E3.3e; There are quiet, low stimulus areas and seating alcoves that provide privacy when required.</p> <p>E3.3e: E3.4.c; There is a safe and secure outside walking area and gardens area that is easy to access for dementia residents.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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.</p>	FA	<p>All bedrooms are single in the three “homes”. There is a mix of fully ensuited, partially ensuited and standard rooms in all homes. There are adequate numbers of communal showers and toilets in all homes. All communal toilets/showers have identifiable signage, privacy locks and privacy curtains. Fixtures, fittings and floor and wall surfaces are made of accepted materials for meeting hygiene and infection control practices and resident safety. There are appropriately placed handrails in the bathrooms and toilets.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>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.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each “home” has spacious open plan 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 or lounge area of each unit dependent on the type of activity.</p> <p>ARHSS D15.3d, ARC D15.3d: Seating and space is arranged to allow both individual and group activities to occur. E3.4b: There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The service has in place policies and procedures for effective management of cleaning and linen practices. The operations manager oversees the laundry and cleaning services. The caregivers carry out the laundry and cleaning duties. The laundry operates 24/7 (link 1.2.8.1). All linen and personal clothing is laundered on site. The laundry area is well equipped with defined clean/dirty area. Personal protective clothing is available. There is adequate linen stock sighted. Chemicals are stored safely in the laundry and cleaning area. 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 (one hospital, four dementia care and one psychogeriatric) are satisfied with the cleanliness of their relative's rooms and the care taken with personal clothing.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>The building has a residential area which is completed but and the office area which includes several offices, staff room, laundry, kitchen and the training room has not been fully completed yet. The management team advised that because of the ongoing building work in the training room, the service maintains "the certificate of public use" (CPU) until full completion of the building. The CPU is valid until 2/3/ 2015.</p> <p>D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There is a civil defence kit and a 10,000-litre water tank for emergency use.</p> <p>There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility. Fire training, emergency evacuation and security situations are part of orientation of new staff and on-going training. Emergency equipment is available. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate (RN). Required corrective action from the previous audit around approval of the fire evacuation scheme from the NZ Fire Service</p>

		<p>has not been obtained yet.</p> <p>ARHSS 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.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated with central heating that is thermostat controlled. Bedroom windows open and are safe with security stays. Residents have access to natural light in their rooms and there is adequate external light in communal areas with doors opening out onto deck areas.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description are available. There is a job description for the infection control coordinator with clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The quality committee and the governing body is responsible for the development of the infection control programme and its annual review. The service has infection control goals around education of new staff and pressure area cares. There are infection control meetings held regularly that comprise of the infection control co-ordinator, facility manager, clinical manager, cook and care staff. The meetings include a discussion and reporting of infection control matters, trends and quality improvements. Information from these meetings is communicated to the clinical meetings. Minutes and graphs are available to staff. The facility has adequate signage and hand sanitizers at the entrance. Notices for visitors asking them not to enter if they have been in contact with infectious diseases have been ordered to place at the entrances. There is a staff health policy.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources</p>	FA	<p>The infection control committee meets monthly and forms part of the quality structure. The facility infection control co-ordinator has been in</p>

<p>to implement the infection control programme and meet the needs of the organisation.</p>		<p>the role since October 2014 and is supported by the clinical manager who has been an experienced infection control nurse. There are organizational infection control meetings six monthly.</p>
<p>Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>There is an infection control manual which includes policies and procedures appropriate to for the size and complexity of the service. There are policies and procedures that include but are not limited to a) infection control nurse responsibilities b) antimicrobial usage c) infection control including renovations and construction; d) accidental exposure to blood e) healthcare waste, f) definitions of infections g) outbreak management. Any changes or updates to the infection control policies are notified at the staff meetings.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand hygiene competency. The IC coordinator (registered nurse) is enrolled to attend the quarterly infection control meeting and education at the district health board. Staff receive infection control on orientation and annual infection prevention and control education.</p> <p>Resident 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 consumer and visitor education around influenza.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.</p> <p>Individual infection report forms and short term care plans are completed for all resident infections. Infections are collated in a monthly register and a monthly report is completed by the infection control co-ordinator. There</p>

		<p>are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint, enablers and the management of challenging behaviours which meet requirements of HDSS 2008. Millvale Lodge is using restraint in a form of hand holding restraint, a T-belt restraint and bed rails. There were no residents at Millvale Lodge with enablers on the day of audit. Policy dictates that enablers should be voluntary and the least restrictive option possible. Policies and procedures are comprehensive and guide staff in the safe use of these. The clinical manager, one RN and five caregivers were interviewed and they were familiar with restraint minimization policy and restraint practices used.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>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.</p>	FA	<p>The restraint coordinator is the clinical manager. The restraint approval process and the conditions of restraint use were recorded and consent for restraint use was logged in the restraint register. The restraint coordinator, a RN and a GP in partnership undertook assessments with the resident and their family/ whanau. The multi-disciplinary team was involved in the assessment process.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Comprehensive assessments were completed prior to use of appropriate restraint intervention. The RN, clinical manager and the GP in partnership with the family/whanau undertakes these. Restraint risk assessment, consent and management forms were completed and</p>

		signed by the resident representative (family / EPOA), RN, and GP and this was documented in the three restraint residents file reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Restraint policies / procedures identify risk processes, consent and monitoring of restraint use when a resident is being restrained. Staff interviews and review of training records provided evidence that staff have received current training on restraint minimization and non-violent crisis intervention. Staff have completed restraint competency assessments. Restraint has been used intermittently and monitoring of restraint use differs between 15 minutes to two hours. Three files reviewed had ongoing monitoring of restraint use.</p> <p>Prior to use of restraint appropriate alternative interventions have been implemented and family discussions were documented and approval was obtained. Behaviour charts were completed and used to identify triggers. Progress notes showed use of de-escalation attempts prior to initiating restraint.</p> <p>Residents care plans includes details of the reasons for initiating the restraint and de –escalation techniques.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Restraint evaluation processes were documented in the restraint minimization and safe practice policy. Three resident's files that were using restraint were reviewed and provided evidence that each episode of restraint was being evaluated and based on the risk of the restraint being used.</p> <p>Two of three restraint use was intermittent 'hand holding' as a form of a restraint. The use of hand holding episodes were evaluated in the care plan and one of these two uses of restraint was removed. Use of bed rail as a restraint was also evaluated and documented in the residents' file. All episodes were also reviewed by the restraint coordinator and the restraint committee.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review	FA	The restraint monitoring and quality review occur and last completed on

<p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>14 October 2014. There is organizational level restraint meeting which was last held on August 2014. Outcomes of these reviews were documented and reported on to the clinical governance group as well as being discussed at the quality and staff meetings. Restraint audit had been completed and required improvements were implemented.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.2</p> <p>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.</p>	PA Low	<p>General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings.</p> <p>There is evidence of enduring power of attorney (EPOA), general practitioner and clinical manager participation in the medical guidance plan.</p>	<p>1) The general consents for one hospital resident admitted in June 2014 have not been signed. 2) The cardiopulmonary status for one rest home resident has been signed by family. There is no letter of mental capacity on the residents file.</p>	<p>1) Ensure all general consents are signed on admission. 2) Ensure the cardiopulmonary status is appropriately signed for.</p> <p>180 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in</p>	PA Low	<p>There is a full time Clinical Manager. There is a RN on duty and rostered in the psychogeriatric wing 24/7. This RN is available for all three areas of the service. The facility is divided in to three homes and rest home and hospital wing (dual services)</p>	<p>There is one RN rostered over 24 hours a day and located in the PG wing and the RN oversees the hospital unit in the evening. The contract with the local DHB states that the psychogeriatric unit and hospital</p>	<p>Ensure RN covers meets the requirements of the ARC and ARHSS contracts</p>

order to provide safe service delivery.		and the psychogeriatric wing have a 16 bed capacity each. Cleaning and laundry duties are completed by the caregivers who are multi-skilled. This is in keeping with providing a homely environment with minimal people entering and exiting the homes on various tasks. Interviews with a RN, five caregivers stated that staffing is adequate to meet the needs of residents.	unit can share a RN between 10pm - 7am only if the service is under 50 beds. There is not always a RN rostered in the hospital as well as the PG unit during the day/evening.	30 days
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Low	There is a standing order list signed by the GP's for hospital residents only.	The standing order form does not have a specified time for review. The maximum number of doses for each standing order is not specified on the standing order form.	<p>Ensure the standing order from complies with the Ministry of Health standing order guidelines 2012.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>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. Frequent fallers are reviewed by the MDT team. Reduction of psychotropic medications are reduced to minimise side effects and monitored by the GP, geriatrician and psychiatric team.</p> <p>The dietitian visits monthly and completes</p>	Hospital resident long term care plan reviewed August 2014 documents a need for referral to dietitian. There is no evidence of a dietitian referral or visit.	<p>Ensure dietitian referrals are initiated and followed-up.</p> <p>90 days</p>

		<p>any resident reviews due and attends to any referrals received for residents with weight loss and 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.</p>		
<p>Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.</p>	<p>PA Moderate</p>	<p>Fire drills have occurred, however an application to the New Zealand Fire Service for approval of fire evacuation scheme has not yet been obtained due to building still in the process of being completed.</p> <p>Discussion with the management team revealed that they were advised that the current CPU covers the evacuation scheme as the building is not fully completed yet, they do not require the NZ Fire services approval for occupancy of the building. The conditions of the CPU state that: all fire safety specified systems remain operational at all times in areas open to the public and that all checks are to be maintained during the time of CPU including the checking of egress routes on a daily basis and keeping a log for the council to inspect. There are records that show these conditions have been met.</p>	<p>Fire drills show how evacuation was staged from the seat of the fire on way to progressing a full evacuation. The NZ Fire service was notified that fire drill occurred but there is no approved evacuation scheme in place and an application to the NZ Fire service has not been made.</p>	<p>Obtain an approval letter of evacuation scheme by the NZ Fire Service.</p> <p>30 days</p>

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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.