

# Admatha Dementia Care Limited - Admatha Dementia Care, Admatha Lodge

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## 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:

<b>Legal entity:</b>	Admatha Dementia Care Limited
<b>Premises audited:</b>	Admatha Dementia Care  Admatha Lodge
<b>Services audited:</b>	Hospital services - Psychogeriatric services; Dementia care
<b>Dates of audit:</b>	Start date: 23 May 2016    End date: 24 May 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	44



# Executive summary of the audit

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## 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

Admatha Dementia Care provides psychogeriatric and dementia level care for up to 57 residents. The service is divided into two separate units - a secure psychogeriatric unit of 25 beds and a secure dementia unit of 32 beds. Each unit is divided into two smaller homes. Occupancy on the days of audit was 22 residents in the psychogeriatric unit and 25 residents in the dementia unit.

An operations manager and clinical manager manages the service. The operations manager has been in the role for five months. The clinical manager is an experienced registered nurse and has been in the role for over two years. Staff interviewed and documentation reviewed identified that the service continues to provide dementia care and psychogeriatric services that are appropriate to meet the needs and interests of the resident group. Family interviewed all spoke positively about the care and support provided.

This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management and staff.

The audit identified that an improvement is required around timeframes for initial care plans.

The service is commended for achieving continuous improvements in the areas of good practice, advanced directives, the quality programme and quality initiatives and reduction of infection rates.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Admatha Dementia Care provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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Admatha is implementing the Dementia Care NZ (DCNZ) quality and risk management system that supports the provision of clinical care. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys. Incidents and accidents are appropriately documented and managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an on-line education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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A well-presented information booklet for residents/families at entry includes information on the service philosophy, services provided and practices particular to the secure unit. Assessment and care plans are developed by registered nurses and reviewed six monthly by the multidisciplinary team. Families are involved in the development and review of the care plan. InterRAI assessments are linked into the comprehensive care plan. A 24-hour multidisciplinary care plan identifies a resident's behaviours and activities or diversions that are successful. There is at least a three-monthly resident review by the medical practitioner. A psychogeriatric community nurse is available as required.

The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident. Individual activity plans are developed in consultation with resident/family.

The medication management system meets legislative requirements. Registered nurses and medication competent caregivers are responsible for the administration of medications. Education and medication competencies are completed annually. The GP reviews the resident's medication at least three monthly. Meals are prepared in the main kitchen located in the lodge and transported to the home. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness for each unit. The facility is divided into two separate units with two homes in each unit. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There are lounge and dining areas, and small seating areas throughout the facilities. Furniture is appropriate to the setting and arranged in a way that allows residents to mobilise. There is a designated laundry, which includes storage of cleaning and laundry chemicals. Chemicals and cleaning trolleys are stored securely when not in use. The service has implemented policies and procedures for civil defence and other emergencies. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided.

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

## Infection prevention and control

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.

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

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	3	46	0	1	0	0	0
<b>Criteria</b>	6	94	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	Admatha has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Seven caregivers, two diversional therapists and four registered nurses (RN) were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with four relatives (two dementia unit and two psychogeriatric).
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents' advance directive where applicable, are on file. All resident files reviewed (three dementia and four psychogeriatric) had copies of the EPOA on file. The service has been involved in a project with the Canterbury DHB to improve advanced care planning and documentation and have exceeded the standard in this area.  Interviews with staff and families state they have input and are given choices. Care plans and 24-hour multidisciplinary care plans demonstrate resident choice as appropriate.

<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>	FA	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is regularly discussed at resident/relatives meetings (minutes sighted).</p> <p>The service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the resident's family and chosen social networks.</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>	FA	<p>Interview with relatives confirm that visiting can occur at any time and families are encouraged to be involved with the service and care. Residents are supported to maintain former activities and interests in the community if appropriate.</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>	FA	<p>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The manager leads the investigation of concerns/complaints. Complaints forms are visible and available for relatives. A complaints procedure is provided within the information pack at entry. The manager documents verbal complaints and these are managed as with written complaints. There were twelve complaints received in 2015 and three for 2016. The complaints register is up to date and complaints sampled have been responded to and managed appropriately with letters of acknowledgement, investigations, staff meetings and letters of response, and outcomes to complainants. Management operate an 'open door' policy.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health &amp; Disability (HDC) Commission. Relatives are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement. Family members interviewed confirmed they received all the relevant information during admission.</p>
<p>Standard 1.1.3: Independence, Personal</p>	FA	<p>There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff</p>

<p>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>were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms. Family interviewed confirmed staff respect their privacy, and support residents in making choice where able. Staff have completed education around privacy, dignity and elder protection.</p> <p>Resident files are stored securely. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings were documented in the seven resident files sampled.</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>	FA	<p>Dementia Care NZ Ltd has a Māori health plan that has been recently reviewed, and a cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Residents who identify as Māori have this recorded on file with an individual health care plan tailored to meet Māori cultural requirements. Linkages with Māori community groups are available and accessed 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>	FA	<p>The resident and family are invited to be involved in care planning and any beliefs or values are discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the residents needs are being met. Discussion with family confirms values and beliefs are considered. Families are provided with two programmes called 'sharing the journey' and 'orientation for families'. Families interviewed spoke positively about these programmes. They provide information and support for family members in understanding dementia. Evaluation of six weekly post admission surveys identified satisfaction with the admission process and communication. Monthly bulletins provided to staff include information such as quality data results, infection control surveillance, and education opportunities. Family/resident newsletters are provided quarterly and include an education component. Residents are supported to attend church services of their choice if appropriate.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other</p>	FA	<p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the seven staff files sampled. Staff comply with confidentiality and the code of conduct. The registered nurses and allied health professionals practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with two operations managers, the clinical manager, registered nurses and care staff confirmed an awareness of professional boundaries.</p>

exploitation.		
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Admatha policies and procedures meet the health and disability safety sector standards. Staff state they are made aware of new/reviewed policies and sign to say they have read them. An environment of open discussion is promoted. Staff report that the operations manager and clinical manager are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The registered nurses have access to external training. Discussions with family were positive about the care they receive. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relatives meetings, quality meetings, infection control meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management. Four family members interviewed spoke very positively about the care provided and were well informed and supported. There are implemented competencies for all staff including caregivers, and registered nurses. There are clear ethical and professional standards and boundaries within job descriptions.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The manager and registered nurse confirm family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Families receive newsletters that keep them informed on facility matters and events. Incident and accident forms sampled and files reviewed evidence that family are notified following adverse events or when there is a change in resident's condition. Resident/family meetings encourage open discussion around the services provided (meeting minutes sighted).</p> <p>There is access to an interpreter service as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Admatha Dementia Care provides care for up to 57 residents requiring hospital psychogeriatric care and dementia specific rest home care. There are two units. One unit (the Lodge) provides care for up to 25 psychogeriatric residents, with 22 residents on the days of audit. The other unit (the Home) provides care for up to 32 dementia-specific rest home level of care residents, with 25 residents on the days of audit. All residents are under an aged related contract. There were no respite residents.</p> <p>Admatha is one of nine facilities in the group of Dementia Care NZ Limited (DCNZ). The nine aged care facilities throughout NZ provide rest home, hospital, medical, dementia and psychogeriatric level care. There is a corporate structure in place, which includes two directors and a governance team of managers. A regional clinical manager for the South Island supports the management team at Admatha. A business plan is in place for all facilities, covering the period July 2015 to June 2016.</p>

		<p>An operations manager and a clinical manager manage Admatha on a daily basis. The operations manager reports directly to the operations team leader and the clinical manager reports directly to the regional clinical manager South Island. The operations manager has been in the role for five months and has a background in management of mental health community support services. The clinical manager (registered nurse) is responsible for the clinical oversight of the service. The clinical manager has been in the role for two years, having worked as an RN for DCNZ since 2011. A clinical director, organisational quality systems manager, operations management leader, a regional clinical manager and an education coordinator/psychiatric RN also support the operations manager and clinical manager.</p> <p>The operations manager and the clinical manager have each attended at least eight hours of education in the past 12 months in relation to their respective roles. The organisation holds an annual training day for all operations managers and all clinical managers.</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>	FA	<p>During a temporary absence of the operations manager, the clinical nurse manager assumes the role with support from the DCNZ management team.</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>	CI	<p>Admatha is implementing a quality and risk management system. The organisation-wide quality and risk operational plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the quality meeting. The operations manager and clinical manager log and monitor all quality data. Meeting minutes are maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Quality improvement reports are provided to the monthly quality meeting. A number of meetings include discussion of quality data and follow-through of quality improvements. The monthly staff bulletin also includes all quality data, incidents and accident, and infection rates. Discussions with staff confirmed their involvement in the quality programme. Data is collected on complaints, accidents, incidents, infection control and restraint use.</p> <p>The internal audit schedule for 2016 is being completed. Areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. Benchmarking with other facilities occurs on data collected. Continuous quality improvement projects (QI) are implemented and the service has</p>

		<p>exceeded the standard in this area.</p> <p>Surveys are completed including (but not limited to) relatives (welfare guardians), and post admission surveys. Surveys reviewed included an analysis and QIs developed where needed.</p> <p>The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The clinical governance group develop and review policies and procedures (link CI 1.1.8). The service has a health and safety management system with designated staff representatives who have completed specific training. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There are identified goals as part of the annual health and safety plan. Progress toward meeting these goals is reported to the monthly health and safety meetings. Falls prevention strategies are in place that includes assessment of risk, medication review, vitamin D, assessments with physiotherapy input, exercises/physical activities, training for staff on detection of falls risk, and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Accident/incident forms for the months of March and April 2016 were sampled. There has been RN notification and clinical assessment completed within a timely manner. Accidents/incidents were also recorded in the resident progress notes. There is documented evidence the family had been notified promptly of accidents/incidents.</p> <p>The service collects incident and accident data and reports aggregated figures to the quality meeting, staff meeting, and the registered nurse (link CI 1.2.3.6). Staff interviewed confirm incident and accident data is discussed at the staff meeting and information and graphs are made available via the staff bulletin.</p> <p>A discussion with the manager confirms 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</p>	FA	<p>There are human resources policies to support recruitment practices. Seven staff files sampled (the clinical manager, one registered nurse, three caregivers, one cook, and one diversional therapist) contained all relevant employment documentation. Current practising certificates were sighted for the registered nurses (RN) and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>An education planner in place covers compulsory education requirements. The service has exceeded the</p>

requirements of legislation.		standard for the provision of education and training for staff. The RNs have completed InterRAI training. Clinical staff complete competencies relevant to their role. There are 33 caregivers and three diversional therapists (DT) employed across the dementia unit and psychogeriatric units. Thirty caregivers and the three DTs have completed the required dementia unit standards. Three caregivers are in the process of completion and all have been employed for less than 12 months.
<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>	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The operations manager and the clinical manager is on-site full time and available after hours. There is a registered nurse on duty Monday to Friday for 40 hours per week in the dementia homes and a registered nurse on duty 24/7 in the psychogeriatric unit. The caregivers and family interviewed inform there are sufficient staff on duty at all times.
<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	The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Files are integrated.
<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 prior to entry by the psychogeriatric team and needs assessment coordinators. The clinical manager liaises closely with the assessing teams to ensure the service can meet the assessed resident needs.</p> <p>The service has a well-presented information booklet for residents/families at entry. It is comprehensive and designed so it can be read with ease (spaced and larger print). The service has two programmes "orientation for families" "sharing the journey" which are to support and assist relatives with coming to terms with a resident with advanced dementia and provides education, care and support for the family. Family members interviewed stated they received sufficient information on the services provided and are appreciative of the staff support during the admission process.</p> <p>Admission agreements reviewed in seven files align with the ARC and ARHSS contract. Admission agreements had been signed within a timely manner.</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>	FA	<p>There is a discharge planning and transfer policy to guide staff in this process. Discussions with the service confirm that resident exit from the service is coordinated and planned and relevant people are informed.</p> <p>There is sufficient information to assure the continuity of residents care through the completed internal transfer form, copy of relevant progress notes, copy of medication chart and doctor's notes. A staff member or family member (as appropriate) accompanies the resident to the hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system includes policy and procedures that follows recognised standards and guidelines for safe medicine management practice. Two registered nurses check medications on delivery against the medication charts. RNs and medication competent caregivers administer medications and they have completed annual medication competencies and education.</p> <p>There were no self-medicating residents. The standing orders meet legislative requirements. All medications are stored safely. The medication fridge temperature is monitored.</p> <p>All 14 medication charts reviewed had photo identification and allergies noted. There were no gaps in the administration signing sheets. 'As required' medications had prescribed indications for use. The 14 medication charts had been reviewed three-monthly by the GP.</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>	FA	<p>A kitchen service manual is located in the kitchen, which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. All kitchen staff have attended food safety and hygiene, chemical safety and relevant in-service training. The kitchen is located within the psychogeriatric home and is locked via a combination lock so that only staff can access this area. There is a kitchenette in the dining areas where food is dished up to residents. Containers of food are transported in hot boxes to the dementia unit kitchenettes, where caregivers plate and serve the meals.</p> <p>The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Pureed and normal diets are provided. Resident likes and dislikes are known and alternative foods are offered. Cultural and spiritual needs are met. There were adequate fluids sighted in the kitchenette fridges and supplement protein drinks are available. There is daily monitoring of hot food temperatures, fridge and freezer temperatures, dishwasher rinse temperatures and delivery temperatures for chilled/frozen goods. All perishable foods in the kitchen fridges and freezer were dated. The dry good store has all goods sealed and labelled. Goods are rotated with the delivery of food items. The cook was observed wearing appropriate personal protective clothing. Weights are monitored monthly or more frequently if required. Residents assessed by the dietitian who require supplements received these and this is recorded in the resident's file. The dietitian visits monthly for review of resident nutritional status and</p>

		needs and notes are included in resident files.
<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 (as appropriate). The clinical manager reports that 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 is used to develop care needs and support to provide best care for the residents. Risk assessment tools are reviewed at least three monthly. InterRAI assessments have been completed for all residents and reviewed at least six monthly. The outcomes of InterRAI assessments including the risk assessments, were reflected in the long-term care plans reviewed. The diversional therapists and other activities staff complete a comprehensive social assessment in consultation with the resident/family.</p> <p>Four psychogeriatric resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The long-term care plan is developed within three weeks of admission. The care plans sampled were comprehensive and documented interventions to meet the resident needs. The outcomes of InterRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs. Care plans demonstrate allied health input into the residents care and well-being. InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process. Family members interviewed confirmed they are involved in the care planning process.</p> <p>Four psychogeriatric resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.</p>
<p>Standard 1.3.6: Service</p>	FA	<p>The care provided is consistent with the needs of residents as demonstrated in the review of the care plans and discussion with caregivers, registered nurses, activity staff and management. Families interviewed state</p>

<p><b>Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>their relative's needs are being met. When a resident's condition changes the RN initiates a GP consultation. Families confirmed they are notified promptly of any changes to health status.</p> <p>Wound assessments and evaluations have been completed for the three current wounds (all minor). The wound nurse and GP have been involved in the wound care and management of previous wounds. Specialist wound and continence management advice is available as needed and the clinical manager and RNs interviewed, could describe this.</p> <p>Continence assessments including a urinary and bowel continence assessment are completed on admission and reviewed three monthly. The company has a continence resource person.</p> <p>A dietitian visits monthly (interviewed) and reviews all residents with actual or potential weight loss. Supplements are used when appropriate. Residents are weighed at least monthly.</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. Pain monitoring forms used to monitor the effectiveness of pain relief are kept in the medication chart folder.</p> <p>Challenging behaviour assessments are well documented, with amendments made to the care plan as required. The company has a non-violent crisis intervention coordinator who supports, advises and educates staff.</p> <p>There is specialist input into the residents care in the psychogeriatric unit. The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment. The psychogeriatric community nurse visits regularly and liaises closely with the psychogeriatric team. The psychiatrist visits residents six monthly.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>A team of two diversional therapists, two diversional therapists in training and an activities coordinator provide an activities programme for part of each day in each of the homes (two dementia level and two psychogeriatric level). Care staff on duty are involved in individual activities with the residents as observed on the day of audit. There are resources available to staff for activities.</p> <p>The programme for the psychogeriatric residents is focused on individual and small group activities that are meaningful including household tasks, reminiscing and sensory activities such as massage and foot spas, baking, garden walks, games music and movies.</p> <p>In all homes programmes regularly revolve around 'theme weeks' with most activities in that week relating to the theme of the week.</p> <p>Entertainment is scheduled fortnightly in each unit. There is a weekly van outing for residents. The activities staff have a current first aid certificate. The service has a wheelchair van.</p> <p>Activity assessments, activity plan, 24-hour MDT care plan, progress notes and attendance charts are</p>

		<p>maintained. Resident and family meetings are held.</p> <p>A comprehensive social history is completed on or soon after admission and information gathered from the relative (and resident, as able) is included in the activity care plan. A 24-hour MDT care plan is reviewed at least six monthly.</p> <p>Caregivers were observed at various times throughout the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions and dementia. Activities were observed to be occurring in the lounges during the audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>In the files reviewed, initial care plans were evaluated by the RN within three weeks of admission. Nursing care plans reviewed were evaluated three monthly in the psychogeriatric unit by the multidisciplinary team (MDT) and evaluated at least six monthly in the dementia unit, or earlier due to health changes. The family are invited to the MDT reviews. Other health professionals are involved as appropriate, such as the physiotherapist and dietitian. Short-term care plans reviewed had been evaluated as required and resolved and if there is an ongoing problem, it is added to the long-term care plan. There is at least a three monthly review of the resident and their medications by the medical practitioner. Ongoing nursing evaluations occur daily/as indicated and are included within the progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</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>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the needs assessment team. At the time of audit there was one example where a resident's condition has changed and required reassessment to a different level of care (link tracer 1.3.3).</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are</p>	FA	<p>There are policies and procedures in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use information is available. Protective equipment including gloves, aprons, and goggles are</p>

<p>protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>available for use by staff. Staff interviewed were familiar with accepted waste management principles and practices.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service has two facilities including a 32-bed rest home dementia Home, which is divided into two units – Tai has 17 bedrooms and Awa has 15 bedrooms. The 25-bed psychogeriatric ‘Lodge’ is also divided into two homes – Amour has 12 bedrooms and Mon Ami has 13 bedrooms. The Home displays a current building warrant of fitness, which expires on 1 April 2017, and the Lodge displays a current building warrant of fitness, which expires on 1 June 2016. A staff member provides general maintenance. There is a scheduled maintenance plan in place. Contractors are contacted when required. The service employs a property manager to oversee the maintenance programme. Hot water temperature checks are conducted weekly. Hot water is provided at up to 45 degrees Celsius maximum in resident areas. Medical equipment has been checked and calibrated and testing and tagging of electrical equipment has been conducted.</p> <p>Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors from each facility. The interior courtyards and gardens are well maintained with safe paving, outdoor shaded seating, lawn and gardens. The residents can access a secure outdoor area. Interviews with the registered nurses and the caregivers confirmed that there was adequate equipment to carry out the cares according to the resident’s care plans.</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>	<p>FA</p>	<p>A mixture of full ensuite, shared ensuite and communal facilities are provided. There are sufficient communal toilets adjacent to the lounge and dining areas. The number of visitor and resident communal toilets provided is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs.</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>The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient space to allow cares to take place. Bedrooms are personalised.</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>There are large communal lounges and dining areas in each unit (two in the Home and two in the Lodge). There are also smaller sitting areas for residents and families to access. Communal areas in each unit are used for activities, recreation and dining activities. All four dining rooms are spacious, and located directly off the kitchen/servery area. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit.</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>	FA	<p>There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all laundry items are processed by designated laundry staff. Staff attend safe chemical handling and infection prevention and control education and there is appropriate protective clothing available. Cleaners are employed seven days a week. Manufacturer's data safety charts are available for reference if needed in an emergency. Family interviewed report satisfaction with the laundry service and cleanliness of the facility.</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>	FA	<p>The service has a fire and emergency procedures manual. New Zealand Fire Service approved the evacuation scheme for the Home in November 1994. The evacuation scheme for the Lodge was approved in June 2003. Six monthly fire drills are conducted. There is currently a trained person with a first aid certificate on each shift. Fire safety training has been provided. There is a call bell system in place in both facilities. A civil defence kit is stocked and checked monthly. Water is stored, sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. The facility has gas cooking and hot water. There are emergency management plans in place to ensure health, civil defence and other emergencies are included.</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>All communal and resident bedrooms have external windows with plenty of natural sunlight. A mix of underfloor electric heating, wall panels and heat pumps (all of which are electric) heats the facility. Windows open for ventilation. The general living areas and resident rooms were appropriately heated and ventilated. Family interviewed state the environment is comfortable.</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 (IC) programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection control programme is reviewed annually at an organisational level. Annual goals for 2016 are in place. The IC programme includes seven objectives that include performance indicators and evaluation.</p> <p>There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the infection control committee at service and organisational level.</p> <p>The IC meeting happens monthly and at an organisational level six monthly. The facility has access to professional advice within the organisation, from GPs and from an IC consultant.</p> <p>Hand hygiene notices are in use around the facility. There is a staff health policy and staff infection and work restriction guidelines.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The monthly infection control committee meeting includes IC as an agenda item. The IC committee consists of a cross section of staff from across the service. The service also has access to an IC consultant, Public Health, GPs and local community laboratory infection-control team. The IC nurse reviews support from the organisation staff trainer, and she has completed external training.</p>
<p>Standard 3.3: Policies and procedures</p>	FA	<p>There is an infection control manual, which includes policies and procedures appropriate for the size and complexity of the service. There are policies and procedures that include but are not limited to a) infection</p>

<p>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>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 staff meetings and are recorded in the staff bulletin.</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) has completed external training. Staff receive infection control on orientation and annual infection prevention and control education.</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>CI</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The DCNZ infection control nurse collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs with support from the DCNZ quality assurance manager. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly facility infection summary and staff were informed. The data has been monitored and evaluated monthly and annually at facility and organisational level. Care staff interviewed were aware of infection rates. Systems in place are appropriate to the size and complexity of the facility. There is close liaison with the GPs who advise and provide feedback/information to the service. Benchmarking occurs against other Dementia Care New Zealand facilities.</p> <p>An outbreak in May 2015 was appropriately managed, with notification made, extra resources provided, appropriate management of staff, residents and families, and a debriefing post incident.</p> <p>The service has exceeded the required standard around the use of infection control surveillance data to develop a project and reduce UTI incidence in the psychogeriatric unit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with caregivers and nursing staff confirm their understanding of restraints and enablers. There were no residents using enablers on the day of audit.</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>Responsibilities and accountabilities for restraint are outlined in the restraint policy and include roles and responsibilities for the restraint coordinator (RN) and approval group. A restraint approval group meets six monthly. The group includes the restraint coordinator, clinical manager, operations manager, DT, company educator and a family representative.</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>Assessments are undertaken by the restraint coordinator/RN in partnership with the resident and their family. Restraint assessments are based on information in the care plan, family, staff and GP consultation and during observations. The restraint assessment tool is completed for residents requiring an approved restraint for safety. There is provision for emergency restraint if required for safety of the residents, other residents/staff.</p> <p>Ongoing consultation with the family and staff is evident through multidisciplinary meetings and facility meetings. There were three psychogeriatric level residents with the use of restraint as required (two H restraints and one seat belt). Two restraint files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p>

		<p>Restraint authorisation is in consultation/partnership with the family, restraint coordinator and GP. Internal audits are completed three monthly, ensuring all restraint processes are completed as per the restraint policy and procedures. The restraint coordinator reports that each episode of restraint is monitored at predetermined intervals, depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form (sighted).</p> <p>A restraint register is in place providing an auditable record of restraint use. This has been completed for all residents requiring restraints.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur monthly in the registered nurses meeting and six-monthly as part of the multi-disciplinary review for the resident on restraint. Families are included as part of this review. A review of two files of residents using restraints identified that evaluations were up-to-date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>At the monthly facility quality meetings, RN meetings, staff meetings and six-monthly restraint meetings, restraints are discussed and reviewed. Any incidents of emergency physical restraint (which are infrequent and documented, and investigated through the incident reporting system) are also reviewed at these meetings. Meeting minutes include a review of the restraint and challenging behaviour education and training programme for staff. Staff receive orientation in restraint use on employment. The company non-violent crisis intervention coordinator provides training for staff. There is internal benchmarking.</p>

## 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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	All resident files sampled demonstrated that residents are reviewed by a GP within two working days of admission and that assessments and long-term care plans had been completed within three weeks of admission. Four of seven files sampled documented an initial assessment completed within 24 hours of admission and an initial care plan completed within 48 hours of admission.	Three of seven files sampled (two psychogeriatric and one dementia level) did not have an initial care plan within 48 hours of admission and one further initial care plan (psychogeriatric level) was not dated.	<p>Ensure all residents have an initial care plan completed within 48 hours of admission.</p> <p>90 days</p>

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	CI	A quality improvement project was identified in 2015, around end of life care and advanced care planning.	<p>A joint project was implemented between Dementia Care NZ and the Canterbury District Health Board with a pilot scheme conducted to trial a medical care guidance plan (MCGP). Dementia Care NZ had identified that current advanced care planning documentation did not meet the needs of residents who were not mentally competent to contribute to end of life plans. A document developed by DCNZ called ‘thinking of your loved ones’ was incorporated in to the MCGP. The trial was completed at the end of February 2016 and has been evaluated by the district health board.</p> <p>A review of the trial was conducted at Admatha to gauge the response of registered nurses and families. The evaluation has concluded that the use of the document has improved the experience of discussing end of life care for registered nurse and family members, with better understanding from changes to language and format of questions. Advised, that the intention is for a nationwide roll out of the document.</p>

<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	<p>CI</p>	<p>Services provided at Admatha adhere to the health and disability services standards. There are well-developed manuals for all areas of the service. Dementia Care NZ has developed a Clinical Governance group to provide excellence in clinical practice. The group has specific terms of reference and includes senior management staff from the organisation and from each of the nine Dementia Care NZ homes, as well as external clinical experts. Projects and improvement outcomes are shared with all facilities to mitigate risk and to ensure that clinical excellence is maintained. Individual homes such as Admatha also develop quality and clinical improvement projects.</p>	<p>The Clinical Governance group was set up in 2014, in response to growth within the organisation and a need to ensure that clinical excellence was maintained throughout each of the nine homes owned by Dementia Care NZ. The organisational response to the increase in registered nurses employed because of the company growth was to develop the Clinical Governance group. Terms of reference for the group are documented and include providing strategic clinical leadership and direction.</p> <p>The group comprises the director of Dementia Care NZ, the clinical director, the two regional clinical managers (north and south), and the group educator/psychiatric RN.</p> <p>Monthly meetings are held to conduct analysis of clinical quality indicators, development and endorsement of clinical quality activities, policy development and review, case studies, education for clinical managers including post graduate study, and sharing of information with the clinical teams.</p> <p>Projects have been identified as a result of the collation of the clinical data and include falls prevention/reduction (link CI 1.2.3.6); benchmarking of urinary tract infections (UTI) identified that Admatha data was consistently higher than other similar facilities. The improvement project that ensued has reduced the number of UTIs at Admatha (link 3.5.7); a wound and skin integrity project; an End of life care project; and professional development pathways for clinical managers and registered nurses.</p> <p>The effectiveness of the clinical governance group is continually evaluated through meeting minutes, review of projects and outcomes, sharing of information between facilities, staff surveys, family surveys, retention of staff, engaging of external clinical experts for objective opinions and views, review of benchmarking clinical indicators and review of the outcomes of continuous quality improvement projects.</p>
<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the</p>	<p>CI</p>	<p>The organisational quality and risk management team have developed the quality and risk operational plan for DCNZ for 2016. The team includes all operations and clinical managers,</p>	<p>The quality programme is reviewed regularly to assess achievements with set targets.</p> <p>The quality and risk management team for Admatha meets monthly to review the quality and risk management plan and goals, and to receive a comprehensive quality report. Benchmarking with other Dementia Care NZ</p>

<p>quality management system.</p>		<p>regional clinical managers, the directors, and the quality systems manager. The plan includes the service philosophy, quality and risk management goals and objectives, a quality plan, a system for monitoring and corrective actions process and the implementation of policies and procedures.</p> <p>Clinical indicators have been identified for all areas of service delivery with benchmarking occurring across the group.</p>	<p>facilities with rest home dementia and psychogeriatric level care occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents, staff accidents) and clinical record audits. At service level, incident/accident reports are collated. Analysis of trends occurs and comprehensive monthly reports are written including ongoing review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. The organisation has introduced specific resource roles. Registered nurses are allocated a role and provide information, support and best practice resource to staff. These roles include a wound resource nurse, a falls coordinator, and a continence/skin integrity resource person.</p> <p>The benchmarking data collated for 2015 and 2016 provides evidence of the achievement towards the set goals within the quality and risk operation plan. Falls rates and infections at Admatha are at the lowest rate for the group. There has been minimal pressure injuries reported. The satisfaction survey for 2015 recorded that all respondents would recommend the service to family and friends.</p>
<p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>CI</p>	<p>The quality manager for the group conducts quality analysis for Admatha. Data is collated monthly and annually and comparisons are made between the nine facilities owned by the DCNZ. Comparisons are made and the rates for each aspect of the benchmarking indicators have been identified. Clinical indicators have been developed and form part of the quality programme and quality goals for DCNZ. The monthly data summary includes complaints, compliments, hospital admissions, staff incidents and accidents, falls, falls with injury, medication errors, behaviours, use of restraint/enablers and infections. The service collects data on a monthly basis for analysis and comparison with the other DCNZ homes. This is to</p>	<p>A falls reduction/prevention project has been identified as a group wide initiative and is being implemented at Admatha. The aim of the project is to minimise fall incidents in each facility. The rate of falls within each unit is gathered monthly, as part of benchmarking clinical indicator data. A falls coordinator (registered nurse) has been appointed at Admatha.</p> <p>The project has included:</p> <ul style="list-style-type: none"> <li>i) Using a falls map and other validated falls assessment tools. A white board communication system has been set up in the nurses' station, to identify when and where falls have occurred. This is to increase vigilance with resident supervision and provides a visual reference for caregivers.</li> <li>ii) The falls coordinator has facilitated and coordinated education to staff (March 2016) and a falls competency package is part of staff competencies. This has been provided to increase staff awareness around falls minimisation.</li> <li>iii) A register of residents on vitamin D has been set up and is updated monthly.</li> </ul>

		<p>identify any trends, and areas for improvement. The clinical governance group reviews the clinical indicator data. As part of clinical excellence, a number of resource roles have been developed including wound resource nurse,</p>	<p>iv) Falls prevention policies and procedures have been developed/reviewed.</p> <p>v) Antipsychotic medication use is monitored, with inappropriate prescribing or negative effects mitigated or reduced.</p> <p>The outcomes of the falls minimisation project at Admatha have been evaluated and indicate that overall falls for both the dementia units and the psychogeriatric units are below the clinical indicator rate of 11.09 for all of 2015 and 2016 to date. In particular, the dementia unit rates have consistently been the lowest of all Dementia Care NZ rest home dementia units for this period.</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>The education and training programme for the year, is based on compulsory training programmes, competency packages and external access to training.</p>	<p>The service has identified training and education for staff as a quality and risk operation plan goal. An education officer (registered nurse) is employed by Dementia Care NZ to facilitate the education programme for all sites.</p> <p>The education programme includes a comprehensive orientation programme for new staff. The half-day session includes introduction of key staff, infection control, restraint minimisation and clinical care. The education programme is supported with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling, health and safety, abuse and neglect and restraint. All care staff are supported to complete first aid qualifications and the ACE programme, including dementia unit standards. The annual education programme is comprehensive and includes programmes designed and implemented by the service. The "best friends approach to care" programme is designed to support caregivers and registered nurses to adapt a best friend approach to residents with dementia. Regular "Best Friends Approach to Dementia Care" (putting yourself in their shoes) training is carried out for all staff. This is based on the service's vision, values and philosophy. A monthly evaluation of incident reports including 'behaviours that challenge' identifies good use of de-escalation techniques. Education around behavioural and psychological symptoms of dementia training was provided in April 2016. Non-violent crisis intervention training and intercultural awareness training is ongoing at Admatha. In-service education sessions include input from external specialists and clinical policies and procedures are updated to reflect good practice. Professional development training for clinical managers is provided with a group wide forum held bi-annually (last</p>

			<p>conducted in March 2016). Registered nursing staff are supported to complete post graduate qualifications. The clinical manager is currently completing post graduate study.</p> <p>The effectiveness of the education programme is evidenced by low care staff turnover (some staff have been in their roles for over 10 years); retention of registered nurses; and positive feedback from family surveys that show high satisfaction with the clinical care provided. A specific, clinical manager led project, relating to inappropriate prescribing of medications for residents with cognitive change, has resulted in a review of antipsychotic medication prescribing and improvements and outcomes for residents. Staff interviewed advised that they receive valuable support and education around the management of challenging behaviours and were conversant with the 'best friends' approach to resident cares.</p>
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>All infections are reported and data is collated and analysed for trends. When trends are identified the service uses this information to develop plans to reduce infection rates.</p>	<p>In early 2015, analysis of infection control data identified an increasing incidence of UTIs in the Admatha Lodge (psychogeriatric unit). All residents were identified to be faecally incontinent and the most common pathogen was identified as E coli. A practicing microbiologist provided external training for all staff in March 2015 and the clinical manager in conjunction with the current policy, reviewed research. This resulted in improved practice in prevention (through hygiene cares), assessment and treatment of UTIs. Because of these interventions, rates of UTIs in Admatha Lodge have reduced from seven residents in early 2015, to an ongoing rate maintained at one or two residents since June 2015.</p>

End of the report.