

Millvale Lodge Lindale Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Millvale 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: 1 June 2016 End date: 2 June 2016
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	40

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Millvale Lodge Lindale is part of the Dementia Care New Zealand (DCNZ) group, which is privately owned. The service is certified to provide rest home, hospital and dementia level of care for up to 47 residents. On the day of the audit, there were 40 residents.

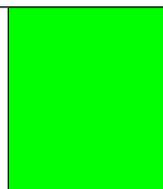
This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, relatives, general practitioner, management and staff. Relatives and residents commented positively on the standard of care and services provided at Millvale Lodge Lindale.

The facility is managed and operated by an acting operations manager and an experienced clinical manager/registered nurse who has been in the role eighteen months. The north island regional clinical manager is also based at the site. The team are supported by the owner/directors, a clinical director, quality systems manager, operations management leader and an educator/psychiatric RN based in Christchurch.

Four of five findings from the previous certification have been addressed in regards to consents, registered nurse cover, dietitian referrals and standing orders. One finding remains around an approved evacuation scheme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

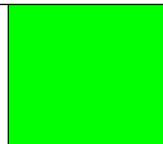


Standards applicable to this service fully attained.

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. Family members are informed in a timely manner when their family members health status changes. The complaints process and complaints forms were displayed on the family noticeboard. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

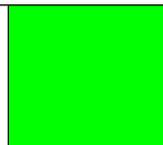


Standards applicable to this service fully attained.

The quality and risk programme includes quality improvement initiatives generated from meetings, resident, family and staff feedback and through the internal audit systems. Millvale Lodge has a current business and quality plan to support quality and risk management systems. Millvale Lodge implements an internal audit programme and collates data for comparisons against other Dementia Care New Zealand facilities. There is a benchmarking programme in place across the organisation. Relative surveys are undertaken annually. Incidents and accidents are appropriately managed. Staff requirements are determined using an organisation service level/skill mix process and documented. The service has a documented and implemented training plan.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

Assessments, care plans, interventions and evaluations are the responsibility of the registered nurses. The multidisciplinary team and families are involved in the review of the care plan. The outcomes of the interRAI assessments are linked into the comprehensive care plan. A 24-hour multidisciplinary care plan identifies a resident's behaviours and, activities or diversions that are successful. There is at least a three monthly resident review by the general practitioner. Allied health professionals as relevant are involved in the residents' care. The service contracts a physiotherapist, dietitian and podiatrist.

The activity team provides separate programmes for the rest home/hospital and dementia care homes residents that includes meaningful activities and meets the recreational needs and preferences of each resident. Individual activity plans are developed in consultation with the family and resident (as appropriate).

The medication management system meets legislative requirements. Registered nurses and senior 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.

All meals and baking is prepared on site. The menu has been reviewed by a dietitian. Resident dislikes and dietary preferences are met. There are nutritious snacks available 24 hours in the dementia homes.

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.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		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 assessed for restraint. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

Standards applicable to this service fully attained.

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

Summary of attainment

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

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	17	0	1	0	0	0
Criteria	0	40	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)
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 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consent has been obtained and signed in all five resident files reviewed (one rest home, two hospital and two dementia level of care). The previous finding around general consents has been addressed.</p> <p>Medically indicated not for resuscitation status evidences discussion with the EPOA/family. The GP or specialists have completed a letter of mental capacity for residents where appropriate in the files reviewed. The previous finding around cardiopulmonary status has been addressed.</p> <p>Interviews with families state that they are involved in decisions affecting the residents care.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	FA	<p>The service has complaints policy and procedures in place and residents and their family/whānau are provided with information on the complaints process on admission. Complaint forms are available at the entrance of the service. Four caregivers (three rest home/ hospital and one dementia care), one registered nurse (RN) and the clinical manager interviewed, were aware of the complaints process and to whom they should direct complaints. A complaints folder is maintained with a current on-line complaints register. There have been three complaints recorded for 2015. There have been three complaints for 2016 to date including one verbal, one written and one</p>

<p>understood, respected, and upheld.</p>		<p>from the DHB. All complaints are well documented including investigation, action plans, follow-up and resolution. Advocacy has been offered to complainants. Complaints are discussed at the monthly quality improvement meetings and staff meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy in place and information on the services is provided at the time of admission. Family members have regular contact with the clinical manager, who has an open-door policy. Incident forms reviewed identified family were informed. Discussion is entered onto the significant event log held in the resident files. Family members (one hospital and one dementia level of care) interviewed stated that they are always informed when their family member's health status changes.</p> <p>The information pack and admission agreement is discussed with resident/family as part of the admission process. A site specific Introduction to Dementia home booklet provides information for family, friends and visitors visiting the facility. Families receive a full orientation to the service. Family support meetings are held monthly with a independent facilitator . Resident meetings are held monthly.</p> <p>The service has policies and procedures available for access to interpreter services and residents (and their family/whānau).</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Dementia Care New Zealand Limited (DCNZ) is the parent company for Millvale Lodge Lindale. Millvale Lodge Lindale provides rest home, hospital (geriatric) and dementia level care for up to 47 residents. There are 20 dual purpose beds in the rest home/hospital home. There are two dementia care homes, one with 12 beds and the other with 15 beds. One the day of audit there were six rest home residents, 12 hospital residents and 22 dementia level of care residents. All residents, including one under 65 years in the dementia home, were under the ARCC.</p> <p>DCNZ has a corporate structure in place which includes the two owners/directors and a governance team of managers and coordinators. The north island regional clinical manager supports the acting operations manager (non-clinical) and the clinical manager.</p> <p>The vision and values of the organisation underpin the philosophy of the service. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states</p> <p>There is Strategic plan for 2015-2018 and a business plan for 2015-2016 in place for all facilities. The 2015 organisational goals has been reviewed by the governance team, clinical director, quality systems coordinator and company educator. Goals achieved include embedding of the interRAI assessments, recruitment and retention of staff, professional development and the implementation of a falls coordinator and falls mapping to reduce falls. Goals set for 2016 include raising the profile of diversional therapy, improving the standard of laundry services and</p>

		<p>increasing food satisfaction by 50%.</p> <p>An acting operations manager (also the facility administrator with previous experience as operations manager) and a clinical manager/RN are responsible for the daily clinical and non-clinical operations of the facility. The clinical manager (registered nurse) has had 20 years nursing experience including aged care. She has been in the role since October 2014.</p> <p>An organisational quality systems manager, a company clinical director, education coordinator/psychiatric RN and owners/directors regularly visit the facility and provide support to the team at Millvale Lodge Lindale.</p> <p>The organisation holds an annual training day for all operations managers and all clinical managers. Both managers have attended at least eight hours of training relevant to their roles.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation-wide risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the quality meeting, health and safety/infection control committee and facility meetings. The acting 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 (QI) reports are provided to the monthly quality meeting. Staff interviewed confirmed involvement and feedback around the quality management system. The service analyses the trends and a comprehensive report is completed that includes outcomes and further actions required at a facility and organisational level. Quality data and graphs are included in the staff newsletter.</p> <p>Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule has been completed as per schedule. Areas of non-compliance (less than 100%) identified in audit results have a corrective action plan developed and entered on-line, followed up and signed-off as completed. Benchmarking with other facilities occurs on data collected.</p> <p>The annual family survey conducted in March 2016 evidenced families/EPOA were overall very satisfied (97%) with the service. Survey evaluations have been conducted for follow-up and quality improvements developed where required. Residents and families are informed of survey outcomes through family/resident meetings.</p> <p>The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with current best practice. Clinical policies are linked to the InterRAI assessment tool. Policies and procedures are reviewed regularly at clinical governance level.</p> <p>Falls prevention strategies are in place that includes assessment of risk, medication review, vitamin D administration, physiotherapy assessments and involvement, exercises/physical activities, training for staff on falls risk and prevention, and awareness of environmental hazards. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The service has implemented a</p>

		reduction in falls project that is linked to the business/quality goals. The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The health and safety representative (interviewed) has completed Stage 1 Health and safety and transition training. The health and safety committee meet monthly and review accidents/incidents, investigations and outcomes and hazard management. The service achieved primary status of the ACC workplace safety management practices in January 2015.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Discussions with the acting operations manager and clinical manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There is evidence of one section-31 notifications made for a stage three pressure injury. There have been no outbreaks.</p> <p>Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Six accident/incident forms reviewed for the month of May 2016 identified they were fully completed and followed up appropriately by the registered nurse. All incident/accident forms reviewed evidenced the family had been notified promptly of the incident by phone.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Staff orientation policy and procedures includes training and support packages for all staff across the services. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications and experience. Copies of practising certificates were sighted for all registered nurses and allied/medical staff. Six staff files reviewed (clinical manager, two RNs and three caregivers) contained job descriptions, performance appraisals and relevant recruitment documents.</p> <p>The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>The organisation has an educator (psychiatric trained RN) who is the behavioural and psychological symptoms of dementia (BPSD) trainer and advisor and the assessor for career force home standards. The service has a BPSD coordinator/RN.</p> <p>The education in-services have been completed as scheduled. The annual training programme well exceeds eight</p>

		<p>hours annually. Staff unable to attend mandatory training complete competency packages. Four RNs and the clinical manager are interRAI competent. Registered nurses are supported to attend external education.</p> <p>The organisation has a programme called 'best friends approach to care', which comprises three one-hour sessions for all staff. The programme is part of the annual education plan and includes promoting the approach that care staff are like the residents 'best friend'. The programme is linked to the vision and values of the organisation.</p> <p>All 24 care staff rotate through the three homes. Twenty one caregivers have completed the dementia home standards. Two caregivers who have been employed less than one year have commenced training and one caregiver has been recently employed in April 2016.</p> <p>There are three diversional therapists (DT) in training progressing through their homes.</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>	FA	<p>Rosters are in place and show that sufficient staff are rostered on across the rest home/hospital and two dementia homes for all shifts to manage the care requirements of the residents.</p> <p>There is one registered nurse on duty in the hospital 24/7. As of November 2015, the service no longer provides psychogeriatric care. Therefore, there is no longer a finding around 24 hour RN cover, for psychogeriatric services. This previous audit finding has been addressed.</p> <p>The clinical manager is employed full-time Monday to Friday and provides on call cover. The regional clinical manager based at Millvale Lodge has a current practicing certificate.</p> <p>Interviews with caregivers, residents and family members confirmed that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system includes policy and procedures that follows recognised standards and guidelines for safe medicine management practice. The RN on duty checks medications on delivery against the medication charts. All medications in stock were within the expiry dates. Registered nurses and senior caregivers administer medications and they have completed annual medication competencies annual medication education. The RNs have attended syringe driver training and refreshers.</p> <p>There were no self-medicating residents. The standing order instructions meet the legislative requirements for standing orders and have been reviewed annually by the GPs. The previous finding around standing orders has been addressed. The medication fridge temperature is monitored daily. All eye drops sighted in the medication trolleys were dated on opening.</p> <p>All 10 medication charts reviewed were current, had photo identification and allergies noted. The medication charts had been reviewed by the GP at least three monthly.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <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>The service employs two qualified cooks and a relieving cook. All baking and meals are cooked on-site in the main kitchen. The cook on duty is supported by a tea kitchen assistant. The company dietitian reviews the four weekly menu. The main meal is in the evening. The cooks are involved in providing feedback on the meals prior to the reviews. Food is transported in hot boxes to the home kitchenettes where the meals are served from the bain-maries.</p> <p>The cook (interviewed) receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in kitchen. Special diets such as diabetic desserts and alternatives for dislikes are accommodated. Religious needs are met. High protein drinks and nutritious snacks were sighted in the dementia kitchenettes and readily available in the kitchen fridges.</p> <p>A daily log is maintained of end cooked food temperatures, fridge and freezer temperatures. All foods are dated in the chiller, fridges and freezers. Chemicals are stored safely. Cleaning schedules are maintained.</p> <p>Food services staff have completed food safety unit standards and chemical safety.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The care provided is consistent with the needs of residents as demonstrated in the review of the care plans and in discussion with care staff. Families interviewed state their relative's needs are being met. When a resident's condition changes, the RN initiates a GP or nurse specialist consultation. Families confirmed they are notified promptly of any changes to health status. Short-term care plans are used to guide staff in the delivery of care for short-term needs.</p> <p>Wound care assessment and management plans and ongoing evaluations have been completed for 10 wounds (three hospital and seven dementia care residents), and two chronic ulcers (one hospital and one dementia care resident). There was one stage-three facility acquired pressure injury (hospital level) on the day of audit. There is documented evidence of GP, nurse practitioner and wound nurse specialist involvement in wound care management.</p> <p>Specialist wound and continence management advice is available as needed and the clinical manager and RN (interviewed) could describe this.</p> <p>Continence assessments include a urinary and bowel continence assessment completed on admission and reviewed three monthly.</p> <p>Pain assessments had been completed for all residents with identified pain. Abbey pain assessments were completed for all residents unable to express pain. Pain monitoring forms are used to monitor the effectiveness of pain relief.</p> <p>Nutritional screening is completed for all residents. Residents identified at risk or with weight loss are referred to</p>

		<p>the dietitian. Appropriate interventions for weight loss have been documented. Dietitian referrals have been initiated and followed up in the resident files as required. The previous finding around dietitian referrals has been addressed.</p> <p>Challenging behaviour assessments are well documented with amendments made to the care plan as required. The company has a BPSD educator/co-ordinator and behaviour management specialist who support, advice and educate staff. Behaviours that challenge are well identified through the assessment process in the resident's files reviewed. Twenty-four-hour multidisciplinary care plans describe the resident's usual signs of wellness, changes and triggers, interventions and de-escalation techniques (including activities) for the management of challenging behaviours. Behaviour charts and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours.</p> <p>Strategies for the provision of a low stimulus environment could be described by the care team and diversional therapist (in training). Each dementia home has spacious gardens and walking paths.</p> <p>The caregivers stated they have the equipment available to safely deliver care as documented in the resident care plans including pressure injury prevention equipment and hoists. There were adequate supplies of consumables sighted such as gloves and aprons.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs three diversional therapists (DT) in training and one relieving activity person who is a caregiver. There is a DT in training or activity assistant for the rest home/hospital seven days a week from 10am to 5.30pm. The DT in training for the dementia homes covers 1.30 to 5.30pm daily. There has been a recent appointment two weeks ago and there is now a DT in training for each dementia home during the week and one on the weekends. Caregivers were observed on the day of audit spending one on one time with dementia care residents at various times of the day. The DTs in training stated there were good activity resources available.</p> <p>There are separate activity programmes for each home with some set activities with the flexibility to add or change activities as required to meet the resident's needs/preferences. Events and themes are celebrated. Pet therapy, entertainers, outings and shopping are included in the programme. Volunteers (families) are involved in assisting with activities as appropriate. One on one time is spent with residents who do not wish to participate in the group programme.</p> <p>Dementia care residents can move between the two homes and attend group under supervision, such as entertainment in the rest home/hospital lounge. The programme for the dementia care residents is focused on individual and small group activities that are meaningful including household tasks, reminiscing and sensory activities.</p> <p>Social profile, activity assessment, activity plan and 24 hour MDT care plan were completed and reviewed in the resident files reviewed. Resident meetings are held monthly and open to families to attend.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans were evaluated by the RN within three weeks of admission in the files reviewed. Nursing care plans and the 24-hour multidisciplinary care plans have been reviewed three monthly by the multidisciplinary team (MDT) and evaluated at least six monthly or earlier due to health changes. The family are invited to the MDT reviews. Other health professionals are involved as appropriate, such as the physiotherapist and dietitian. Short-term care plans are utilised for short-term needs and reviewed as required with any unresolved ongoing problems added to the long-term care plan. Ongoing nursing evaluations occur daily/as indicated and are included in the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current warrant of fitness, which expires 16 May 2017.</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>	PA Low	<p>The business project manager at head office has been actively engaging with the Fire Service to obtain an approved fire evacuation scheme. The service has completed remedial work required including the installation of firewalls and is awaiting a final sign off on the evacuation plan. The most recent site meeting was February 2016. Correspondence was sighted. Six monthly full evacuation fire drills have been held. In the event of a fire, there would be a full evacuation until the staged evacuation plan is approved.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The clinical manager (previously an infection control nurse) is mentoring an RN into the role. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Infection control data is collated monthly and reported at the infection control meetings. Infection control data is included in the monthly 'Staff Bulletin' on display for staff. There are six monthly</p>

<p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>organisation Skype meetings for all the North Island infection control officers where surveillance is discussed and education occurs. Benchmarking occurs within the organisation against other facilities. Internal infection-control audits are completed and assist the service in evaluating infection-control needs. The infection control goals are reviewed twice yearly. Staff complete annual hand hygiene audits. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregivers and registered nurse confirmed their understanding of restraints and enablers. There were no residents using enablers on the day of audit. There is a provision for the use of emergency restraint for three dementia residents. This includes two residents who have been assessed for the use of T-belt in an emergency, and one resident who has an arm holding restraint for the least amount of time required. Staff have attended challenging behaviour, BPSD and restraint minimisation and safe practice training.</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)
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Low	The business project manager at head office has been actively engaging with the Fire Service to obtain an approved fire evacuation scheme. The service has completed remedial work required including the installation of firewalls and is awaiting a final sign off on the evacuation plan. The most recent site meeting was February 2016. Correspondence was sighted. Six monthly full evacuation fire drills have been held. In the event of a fire, there would be a full evacuation until the staged evacuation plan is approved.	The fire evacuation plan has yet to be signed off and approved by the fire service.	Ensure there is an approved evacuation plan in place. 90 days

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.