

Avonlea Dementia Care Limited - Avonlea Dementia Care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Avonlea Dementia Care Limited
Premises audited:	Avonlea Dementia Care
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 10 July 2017 End date: 11 July 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	61

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

Avonlea Dementia Care provides hospital (medical, geriatric and psychogeriatric) and dementia level care for up to 65 residents including one funded respite bed. The service is divided into six separate units - a secure psychogeriatric unit, four secure dementia units and a hospital unit. Occupancy on the days of audit was 61 residents.

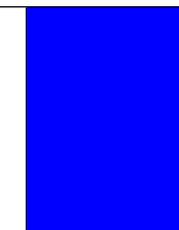
This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management and staff.

An operations manager and clinical manager, manage the service on a day-to-day basis. The operations manager has been in the role for 18 months, having previously managed at another Dementia Care New Zealand (DCNZ) facility. The clinical manager is an experienced registered nurse and has been in the role for four years. They are supported by an organisational management team from DCNZ. Staff interviewed and documentation reviewed identified that the service continues to provide hospital (medical and geriatric), dementia care and psychogeriatric services that are appropriate to meet the needs and interests of the resident group. The resident and families interviewed all spoke positively about the care and support provided.

The audit identified that improvement is required around documentation for sliding scale medication and review of assessments and plans for returning respite care residents.

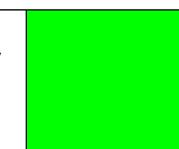
The service is commended for achieving continuous improvements in the areas of good practice, quality initiatives, and engagement of residents through pet therapy and reduction of infection rates.

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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Avonlea 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 of Health and Disability Services Consumer Rights (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. The resident and families 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.		Standards applicable to this service fully attained.
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Services are planned, coordinated and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded into practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive appropriate services from

suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is implemented and includes in-service education and competency assessments. A professional development process is in situ for regulated staff. Registered nursing cover is provided twenty four hours a day, seven days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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A comprehensive information booklet is available for residents/families at entry, which includes information on the service philosophy, services provided and practices particularly to the secure units. The operations manager takes primary responsibility for managing entry to the service with assistance from the clinical manager. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations. Care plans reviewed were based on the interRAI outcomes and other assessments.

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.

Meals are prepared in the main kitchen and delivered in hot boxes to each unit. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. The resident 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. The facility is divided into six separate units. 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 in each unit. 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, security, 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. There were seven residents using restraints and no residents utilising enablers. A register is maintained by the restraint coordinator/registered nurse (RN). Residents using restraints are reviewed monthly in the registered nurses meeting. 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 programme is appropriate for the size and complexity of the service. The infection control nurse (registered nurse) is responsible for coordinating the infection control programme and providing education and training for staff. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. Information is obtained through surveillance to determine infection control activities.

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	2	46	0	2	0	0	0
Criteria	4	95	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Avonlea has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Six caregivers (two from the dementia units, two from the psychogeriatric unit and two from the hospital unit), three diversional therapists and three 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 one resident (only one resident (hospital) was competent to be interviewed) and four relatives (one dementia unit, one psychogeriatric and two hospital level).</p>
<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 is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. All files reviewed (four dementia, two psychogeriatric, two hospital) included completed consents. There was 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 is on file.</p> <p>All files reviewed of residents in the secure units (four dementia, two psychogeriatric) had copies of the EPOA on file. Interviews with staff (hospital), a resident and families state they have input in care and</p>

		are given choices on daily basis. Long-term 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 and/or families 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 confirmed 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>The service has a complaints policy that describes the management of complaints process. Information about complaints is provided on admission. Management operates an open-door policy. Interview with one hospital resident and relatives confirmed an understanding of the complaints process. There is an up-to-date online complaint register. There have been ten complaints (verbal and written) received from January 2016 to current date. All complaints reviewed had noted investigation, timeframes and corrective actions, including letters of acknowledgement. The response to an HDC complaint received in May 2017 was sighted. No further follow-up by the service was required.</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 & 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 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>	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 were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms. The resident and families 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>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 and a cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e) of the aged related residential care contact (ARRC). Residents who identify as Māori have this recorded on file with an individual health care plan tailored to meet Māori cultural requirements. Resident files sampled confirmed this. 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 resident's needs are being met. Discussion with one resident and family members confirmed values and beliefs are considered.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</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 the operations managers, the clinical manager, registered nurses and care staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p>	CI	<p>Avonlea policies and procedures meet the health and disability safety sector standards. Staff stated they are made aware of new/reviewed policies and sign to say they have read them. An environment of open</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>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. A quality monitoring programme is implemented and it 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. Family members interviewed spoke very positively about the care provided and were well informed and supported. There are clear ethical and professional standards and boundaries within job descriptions.</p> <p>The service encourages an environment of good practice. The clinical manager and registered nurses are encouraged to undertake research and develop projects to improve outcomes and satisfaction for residents and their families. Some projects have resulted in a reduction in staff injuries, a reduction in bruising and the development of a sensory/memory room to provide a place to take residents who are agitated and to assist them to de-escalate, and a place for families to go with residents with items from the past providing conversation starters for families. Other projects have included an end of life project to improve the end of life experience for residents and families, the development of a pressure injury awareness week, a reduction in pressure injuries and a trial of a product that has resulted in improved skin integrity for residents.</p> <p>The service has exceeded the required standard around good practice.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<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 nurses confirmed 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 evidenced 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). There is access to an interpreter service as required.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of</p>	<p>FA</p>	<p>The service provides care for up to 65 residents requiring hospital, psychogeriatric and secure dementia (rest home) level care. On the day of the audit, there were ten residents at hospital level care, nine in the psychogeriatric home and forty-two in the four secure dementia homes (including two on respite care). The service has one funded respite dementia bed.</p> <p>The service has an 11-bed psychogeriatric unit, a 10-bed hospital unit, an 8-bed dementia unit, a 16-bed</p>

<p>consumers.</p>		<p>dementia unit and two 10-bed dementia units.</p> <p>There is a strong focus within the organisation to promote independence, to value the lives of residents and staff and this is supported by the vision and values statement of the organisation. DCNZ has an overall 2016 – 2017 business/strategic plan based on “our services”, “our people”, “our environment” and the “sharing of experiences”. The business plan is regularly reviewed. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The clinical manager has been in the role for four years. The clinical manager reports to the national clinical manager and the clinical director. The clinical manager attended and presented at the biannual DCNZ National Forums in advanced nursing practice, competency driven (total of 40 hours annually). The operations manager (non-clinical) of Avonlea has been in the role for 18-months and was previously operations manager of another DCNZ facility. The operations manager reports to the operational management leader at head office. The operational manager is supported by an organisational quality systems manager, education coordinator, a national clinical manager and a clinical director and the owners/directors at head office. The operations manager has attended at least eight hours of professional development including health and safety transition training. The operations manager attends DCNZ seminars and has completed more than eight hours training related to managing a rest home and hospital in the past year.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During the temporary absence of the operations manager, the clinical manager covers the operations manager’s role. During the temporary absence of the clinical manager a senior registered nurse covers for the clinical manager under the supervision of the clinical manager from a sister company of DCNZ located in Christchurch</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</p>	<p>FA</p>	<p>There is a quality plan that includes quality goals and risk management plans for Avonlea. The quality programme is managed by the operations manager and clinical manager. A quality systems manager for the organisation oversees the quality programme ensuring all aspects of quality management is implemented.</p> <p>Interviews with staff confirmed that there is discussion about quality data at various facility meetings including monthly quality improvement meetings and clinical meetings. There is documented evidence in meeting minutes of quality data, trends and analysis. Minutes and the staff monthly bulletin (displayed</p>

improvement principles.		<p>on the staff noticeboard) contain topical information and quality data. Organisational policies meet all current requirements and are reviewed at head office. Staff have access to the policy manuals.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. The operations manager completes environmental and non-clinical audits. The clinical manager undertakes all clinical audits. The internal audit programme continues to be implemented and all issues identified had corrective action plans and resolutions. The quality systems manager completes compliance site audits.</p> <p>Annual welfare, guardian surveys were completed in October 2016. Results were published in the family newsletter. Quality improvements raised and implemented were an increase in activities and ensuring cultural preferences and special dietary needs are captured and communicated to staff. The service has a cultural advisor on staff.</p> <p>The service has a Health and Safety Committee which comprises of a health and safety officer, health and safety representative, manual handling advisor, restraint coordinator and care staff. All committee members have completed external health and safety education. Health and safety objectives for 2017 are known by staff and include a reduction of staff accidents and minimisation of falls.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>The implantation of quality initiatives has exceeded the required standard.</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>There is an accidents and incidents reporting policy. An online incident/accident register is maintained. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality improvement and clinical meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Fourteen incident forms reviewed demonstrated that all appropriate clinical follow-up and investigation had occurred following incidents. Discussions with the operations manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications and were able to provide examples.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>There are human resources management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Current practising certificates were sighted. Eight staff files were reviewed (one clinical manager, two registered nurses, three healthcare assistants, one diversional therapist and one cook) and there was evidence that reference checks and police vetting were completed before</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>employment. Annual staff appraisals were evident in all staff files reviewed for those who have been with the service over twelve months. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Completed orientation was evidenced and staff described the orientation programme. The service uses the “Best Friends” approach to caring for residents and staff complete an in-service education programme on this approach to care.</p> <p>The in-service education programme for 2016 has been completed and the plan for 2017 is being implemented. The service identified not all staff were able to attend education sessions and developed a workbook.</p> <p>The organisation has developed a user-friendly caregiver orientation workbook that includes a self-directed learning package that aligns with the first year of education requirements. The workbook includes the policy and comprehension questionnaire. A second-year workbook has been developed to cover the mandatory requirements of the two-yearly training calendar. Staff receive this workbook at their first annual appraisal.</p> <p>The clinical manager and registered nurses are able to attend external training, including sessions provided by the local DHB. The clinical managers within the organisation attend biannual DCNZ National Forums in advanced nursing practice, competency driven (total of 40 hours annually). Eight hours of staff development or in-service education has been provided annually. All RNs have completed first aid training. The organisation has an education coordinator who is a registered psychiatric nurse. The clinical director leads the professional development project across the organisation.</p> <p>There are 43 healthcare assistants who work in the hospital, dementia and psychogeriatric units. Thirty-nine healthcare assistants have completed the required dementia unit education modules. Four healthcare assistants are in the process of completing national dementia unit modules and have been employed for less than twelve months.</p> <p>Seven of ten registered nurses have achieved and maintained interRAI competency.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. Avonlea roster identifies there is sufficient staffing cover for the safe provision of care for dementia, psychogeriatric and hospital residents.</p> <p>The service has an 11-bed psychogeriatric unit, a 10-bed hospital unit, an 8-bed dementia unit, a 16-bed dementia unit and two 10-bed dementia units.</p> <p>The clinical manager (RN) works full-time Monday to Friday and is available on-call 24/7. Additionally, there is a registered nurse on duty on each shift, seven days per week. In both the hospital unit and psychogeriatric unit. The RN in the hospital unit oversees the dementia units.</p>

		<p>There is a home manager (senior healthcare assistant) on duty in each of the dementia units on morning and afternoon shifts. They are supported by a healthcare assistant on these shifts. On night duty, there is one healthcare assistant on duty in each dementia unit.</p> <p>In the hospital and psychogeriatric units two healthcare assistants support the RNs on the morning and afternoon shifts. A registered nurse is on duty in the psychogeriatric unit and another is on duty in the hospital unit overnight.</p> <p>Staff are visible and available to meet resident's needs, as reported by one hospital resident and family members interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being held securely in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant care staff. Individual resident files demonstrate service integration with only medication charts held on the electronic medication management programme.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents are assessed prior to entry by the needs assessment coordinators and where required by the psychogeriatric team. The operations and clinical managers liaise closely with the assessing teams to ensure Avonlea can meet the prospective resident's needs.</p> <p>Family members interviewed stated that 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 files sampled align with the ARRC and aged residential hospital specialised services (ARHSS) contracts. Exclusions from the service are included in the admission agreement and the information provided at entry includes examples of how services can be accessed that were not included in the agreement. Admission agreements had been signed in a timely manner.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>transfer from hospital to residential aged care form that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur. A file was reviewed of a hospital resident that was transferred acutely to the DHB hospital following a fall.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>The medication management system includes policy and procedures that follows recognised standards and guidelines for safe medicine management practice with the exception of documentation around sliding scale insulin documentation. 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 electronic 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 16 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>	<p>FA</p>	<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. There is a kitchenette in the dining areas in each unit where food is served up to residents. Containers of food are transported in hot boxes to the 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 regularly for review of resident nutritional status and needs and notes are included in resident files.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to residents is recorded should this occur and communicated to the resident and family (as appropriate). The operations manager reported 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>	<p>FA</p>	<p>The information gathered at admission is used to develop care needs and supports to provide best care for the residents. A range of paper-based assessments are completed as well as interRAI assessments. Assessments include (but not limited to); nutritional assessment, continence, and abbey pain. Risk assessment tools are reviewed at least three-monthly. InterRAI assessments have been completed for all residents and reviewed at least three – 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 completes a comprehensive social assessment and comprehensive activity care plan in consultation with the resident/family.</p> <p>Residents with identified behaviours that challenge included behaviour assessment and management plans in place.</p> <p>The two psychogeriatric residents' 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>	<p>FA</p>	<p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The outcomes of interRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs. The care plans sampled included documented interventions to meet the resident's assessed care needs. The long-term care plans reviewed demonstrated allied health input into the resident's care and well-being. Family members interviewed confirmed they are involved in the care planning process.</p> <p>Two files reviewed of residents in the psychogeriatric (PG) unit and three long-term residents across the dementia units all had identified current abilities, level of independence, identified needs and specific behavioural management strategies documented within their care plans.</p> <p>Behaviours that challenge have been identified through the assessment process. 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</p>

		<p>behaviours.</p> <p>Behaviour charts and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours.</p> <p>Care plans were integrated. Physiotherapist assessment, management plans and dietitian assessment and plans were reflected in the LTCPs.</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>	FA	<p>Registered nurses (RNs) and caregivers, follow the care plan and report progress against the care plan each shift at handover (witnessed). If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse, wound care specialist, or the mental health nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>There were six wounds currently being managed by the service and the wound care nurse was involved with the management of PIs for one hospital resident and recently referred for another resident with an ulcer. All wounds have been reviewed in appropriate timeframes.</p> <p>There is specialist input into the residents' care in the psychogeriatric unit as needed. There is evidence in the medical notes of GP communication with the psychogeriatrician in regard to medication review.</p> <p>The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment.</p> <p>Monitoring charts were sighted for food/fluid, behaviours, turning charts and pain.</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>	CI	<p>A team of four full time diversional therapists and five part-time diversional therapists in training provide an activities programme for part of each day in each of the units. 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 units programmes regularly revolve around 'theme weeks' with most activities in that week relating to the theme of the week.</p>

		<p>Entertainment is scheduled regularly in each unit. There is a weekly van outing for residents. The activities staff have current first aid certificates. The service has a wheelchair van and at least two staff attend all van outings. The service has developed a programme with a trained therapy dog that has increased communication and engagement with a number of residents. This has exceeded the required standard.</p> <p>Activity assessments, activity plan, 24-hour MDT care plan, progress notes and attendance charts are 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>	<p>FA</p>	<p>Files sampled demonstrated that the long-term care plans were evaluated at least three-monthly (or earlier if there was a change in health status) for hospital and psychogeriatric residents and at least six-monthly (or earlier if there was a change in health status) for dementia care residents. Care plan evaluations describe progress to meeting goals. There was at least a three-monthly review by the GP. Overall changes in health status were documented and followed up. Reassessments have been completed using interRAI for all residents who have had a significant change in health status since 1 July 2015. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service has updated changes in the long-term care plan.</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>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists, dietitian and other allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed. There was one resident in the dementia unit awaiting reassessment for a higher level of care.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	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 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>	FA	<p>Avonlea is divided into six units, known as homes. There are four dementia units, one psychogeriatric unit and one hospital unit. The facility displays a current building warrant of fitness, which expires on 1 July 2018. 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 home. The interior courtyards and gardens are well maintained with safe paving, outdoor shaded seating, lawn and gardens. The residents can access secure outdoor areas. Interviews with the registered nurses and the caregivers confirmed that there was adequate equipment to carry out the cares according to the residents' 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>	FA	<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 reported 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. 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 six 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 caregivers. 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 reported 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 has approved the evacuation scheme for Avonlea in November 1994. Six-monthly fire drills are conducted. There is 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. 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. 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,</p>	FA	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. Heating throughout the facility is managed from the operations manager's office. Windows open for ventilation.</p>

<p>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>		<p>The general living areas and resident rooms were appropriately heated and ventilated. Family interviewed stated 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>	<p>FA</p>	<p>Avonlea has an established infection control (IC) programme that is being implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The clinical manager is the designated infection control nurse with support from the registered nurses and national clinical manager. The IC team meets as part of the quality team meeting to review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. IC is supported through expert national education bi-annually.</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>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Avonlea. The infection control (IC) nurse has maintained their practice by attending infection control updates. The infection control team (the quality team) is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</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</p>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</p>

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control nurse who has completed training to ensure knowledge of current practice. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.</p> <p>Individual infection report forms and short-term care plans are completed for all resident infections. Infections are collated in a monthly register and a monthly report is completed by the infection control coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, infection control and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities.</p> <p>The service has exceeded the required standard around an implemented plan that has reduced urinary tract infections.</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 confirmed their understanding of restraints and enablers. There were no residents using enablers on the day of audit. There were three residents using restraint in the dementia units (one t-belt and two 'arm restraints') and four in the psychogeriatric unit (one arm restraint and three t-belts). When a resident requires a staff member to gently hold their arms to calm the resident and allow essential cares to be undertaken this is documented as 'arm restraint' and is only used after a full</p>

		restraint assessment, discussion with the family and involvement of the GP.
<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. Three files sampled for residents with restraint demonstrated that 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. Three 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). All restraints are only used intermittently with each of the three records sampled having frequent days when restraint is not used at all.</p>

		A restraint register is in place providing an auditable record of restraint use. This has been completed for all residents requiring restraints.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	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 three files of residents using restraints identified that evaluations were up-to-date.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	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. There is internal benchmarking.

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 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	All 16 electronic medication files sampled had prescribed medications documented including appropriate prescribing for PRN medications. The prescribing documentation was inadequate for one resident.	A resident in the dementia unit currently on a sliding scale (SS) Novarapid. Advised that the electronic system does not have the ability to document the sliding scale instruction. Therefore the system refers to the sliding scale document in resident file. The SS document in the residents file includes a line through the bedtime SS dose. However, it is unclear if it is discontinued as it is not signed and staff interviewed were unsure. Records reviewed did not consistency document what dose of Novarapid was given by the staff administering medication and what the current BSL was. This was followed up with the diabetes physician and addressed on the day of audit. Progress notes and paper-based BSL monitoring charts identified appropriate management of the resident to manage risk. There has been increased monitoring of resident	Ensure instructions for all current medication is clearly documented and administration of extra insulin is clearly documented by staff on the medication record.

			BSLs due to refusal to have food/meals at times and also refusal to have insulin and therefore this finding has been identified as low risk.	30 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	<p>All long-term resident files sampled had a comprehensive suite of assessments completed on admission. The respite resident file sampled was for a resident who had regular respite admissions. A comprehensive assessment had been completed on the first admission (six months prior to the audit) but documented reviews had not been completed for subsequent admissions including the current admission. The sample was expanded to a second resident with more than one respite admission and the same issue occurred in this file. Staff interviewed (a registered nurse and two healthcare assistants reported that neither resident had experienced a change in needs since their initial admission. There was no evidence to indicate that this documentation issue had compromised the care of the residents so the risk is assessed as low.</p>	<p>Two of two respite resident files sampled did not have assessments and care plans reviewed for each ongoing admission.</p>	<p>Ensure assessments and care plans are reviewed each time a resident is admitted.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Dementia Care New Zealand encourages a culture of best practice. Staff, particularly registered nurses and clinical managers are supported to attend external education and to undertake research to gain ideas to develop projects to improve resident outcomes and satisfaction. An example of this is the project to reduce pressure injuries.</p>	<p>In 2016, the team at Avonlea developed a goal to decrease facility acquired pressure injuries. A plan was developed and implemented. Initiatives to achieve the outcome included providing increased staff education around preventing and treating pressure injuries and wound care information and informal and ongoing education from the clinical manager. A competency package relating to pressure injuries was developed and completed by all staff, including registered nurses. Staff bulletins included reminders about pressure injury prevention and discussion around this began being included in handovers. Alert stickers were developed and are placed in communication books to alert staff of residents at risk. As a result of these interventions the number of pressure injuries between January and June 2017 was reduced from the previous six-month period by 71%.</p>

<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>CI</p>	<p>Benchmarking reports are generated throughout the year and an annual review of the data is completed. Quality improvement forms are utilised at Avonlea and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. The service is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified.</p>	<p>The service is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. As a result of quality data collected, the clinical manager feeds back monthly to staff at handover and staff meetings, issues arising and identified trends or issues. Any identified common themes around incidents/infections etc. results in further education and updates at handovers between shifts and meetings. Documentation reviewed identified that strategies are regularly evaluated. Avonlea focused on reducing instances of bruising of an unknown cause and falls prevention in 2016 – 2017 YTD.</p> <p>The service implemented the following strategies that have included (but not limited to): (i) a workshop for RNs and healthcare assistants on careful manual handling, (ii) compulsory in-service on disturbing behaviour management to highlight the importance of completion of behaviour monitoring charts and (iii) and physiotherapist review requested, for those residents identified at risk to reduce instances of harm or injury caused by resident behaviour. A recent review of data, (5 June 2017) evidenced that the instances of bruising of an unknown cause had reduced by 30% in the last six month period.</p> <p>The service implemented the following strategies around falls prevention that included: (i) a falls competency package, (ii) education sessions on falls prevention, importance of hydration, (iii) falls mapping, (iv) purchase of equipment, for example, sensor mats, (v) physiotherapy review of residents following a fall and (vi) encouraging and/or assisting residents to participate in the exercise programme. As a result of the strategies implemented, the facility has remained below the organisational target range of 6.38 falls per 1000 bed nights at 5.18 over a twelve-month period.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated</p>	<p>CI</p>	<p>Interview with three diversional therapists demonstrated that they are continually trying different approaches to improve outcomes for residents. Examples include gardening projects,</p>	<p>In 2016 DCNZ developed the Magic Merlin Project to enable an animal assist/therapy approach to a cluster of Christchurch homes. A puppy was chosen through an identified selected breeding programme in NZ to include the key desirable traits</p>

<p>to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>one to one interventions and regular visits from a trained therapy dog.</p>	<p>required for this specialised work.</p> <p>Avonlea Home as part of the DCNZ Christchurch cluster group has received the benefit of being included in the project. Individual consumer therapy plus a wider and general animal contact experience has ensued.</p> <p>The regular visits from Merlin have resulted in many observed moments of enjoyment and engagement for residents which are difficult to measure in an objective manner. However, tangible improvements have included a significant reduction in agitation and behaviours for five specific residents who have received regular visits from Merlin, and six residents who previously did not speak or spoke unintelligibly have engaged with Merlin and his trainer, speaking to Merlin without signs of confusion and discussing and reminiscing verbally about pets they had owned in the past and then more general reminiscence about the past.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. All infections are individually logged monthly. The data has been monitored and evaluated monthly and annually and is benchmarked internally.</p>	<p>The service implemented the following strategies around reducing the incidents of urinary tract infections (UTIs) that included: (i) education on the importance of hydration, (ii) education session presented by a microbiologist at clinical managers' study day on the prevention and management of UTIs, (iii) introduction of extra fluid rounds in warmer weather and (iv) establishing a toileting regime that meets individual resident's needs. As a result of the strategies implemented, the facility has remained below the organisational target range of 1.51 UTIs per 1000 bed nights at 1.00 in hospital level care, 0.01 psychogeriatric level of care and 1.36 dementia level care over a twelve-month period.</p>

End of the report.