

Millvale House Miramar Limited - Millvale House Miramar

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 House Miramar Limited
Premises audited:	Millvale House Miramar
Services audited:	Hospital services - Psychogeriatric services; Rest home care (excluding dementia care)
Dates of audit:	Start date: 4 September 2017 End date: 4 September 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:	22

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

Dementia Care New Zealand Ltd is the parent company of Millvale House Miramar. The service provides hospital (psychogeriatric) level care for up to 26 residents and rest home level care. On the day of audit, there were 22 residents.

The surveillance audit was conducted against a subset of the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents' and staff files, observations and interviews with relatives, staff and management.

The quality and risk management plan is being implemented and monitored. Key components of the quality management system link to monthly quality meetings and monthly staff meetings.

An operations manager and a clinical manager manage Millvale House Miramar daily. The operations manager has been in the role for the last five and a half years. The clinical manager (registered nurse) is responsible for the clinical oversight of the service.

The previous audit did not identify any shortfalls. This audit identified improvement required around communication from nursing staff to the kitchen and food storage.

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.
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Residents' privacy is maintained, individuality is respected and are not subject to abuse or neglect. 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 member's health status changes. A site-specific introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. 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.
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The organisational quality and risk management plan includes a variety of quality improvement initiatives which are generated from meetings, resident, family and staff feedback and through the internal audit systems. Progress with the quality and risk management plan is monitored through the quality meeting. The operations manager and clinical manager log and monitor all quality data. There is a benchmarking programme in place across the organisation. The internal audit schedule for 2017 is being completed. Areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. Relative surveys are undertaken annually. Incidents and accidents are appropriately managed. Appropriate staff are recruited and provided with a comprehensive orientation. An annual education plan has been implemented and staff have received appropriate

training including dementia specific training. There are sufficient staff on duty, including a registered nurse at all times, to meet the needs of the residents.

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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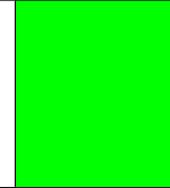
Registered nurses are responsible for assessments, care plan development, interventions, reviews and evaluations. Families are involved in the development and review of the care plans. A multi-disciplinary team review occurs three-monthly. InterRAI assessments are linked into the comprehensive care plan that includes a 24-hour multidisciplinary care plan that identifies a resident's behaviours, activities or diversions that are successful. There is at least a three-monthly resident review by the medical practitioner. A psychogeriatric community nurse visits monthly and as required. Residents are referred and transferred to allied health services and external services when required.

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

The medication management system meets legislative requirements. Registered nurses are responsible for the administration of medications. Education and medication competencies are completed annually. All medications charts have current identification photos and document the resident allergy status. The GP reviews the resident's medication at least three-monthly.

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.

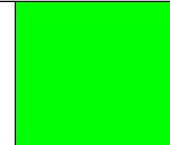


Standards applicable to this service fully attained.

There is a current building warrant of fitness. Emergency and disaster plans in place guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan and fire drills occur six-monthly. There is staff on duty with a current first aid certificate. The service has policies and procedures for effective management of laundry and cleaning practices and was clean during the audit.

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.

Restraint policies 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 six residents using restraints.

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 uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other dementia care NZ (DCNZ) facilities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	19	0	1	0	0	0
Criteria	0	51	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. There are complaint forms and information available at the entrance. Information about the complaints process is provided on admission. Seven care staff interviewed (four caregivers, one registered nurse (RN), one diversional therapist and one activities coordinator) could describe the process around reporting complaints. An established complaints register is included on an access database format. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response.</p> <p>Seven complaints made in 2016 and three complaints received in 2017 year-to-date were reviewed. All complaints reviewed have documented investigation. Timeframes for addressing each complaint are compliant with the Health and Disability Commissioner (HDC) guidelines and corrective actions (when required) are documented. All lodged complaints were documented as resolved. All except one complainant had indicated they were happy with the outcome of the complaint. A recent complaint made in 2017 through the district health board (DHB) was reviewed during the audit process which confirmed that there would be no further action required with the complaint.</p> <p>Following an anonymous complaint to the Ministry of Health, HealthCERT had requested that this audit assess residents' independence, personal privacy and respect, communication, the complaints process, incident reporting and investigation, staff recruitment, orientation and training, staffing levels, interventions provided, evaluations, referral to other health and disability services, the food service, cleaning and laundry processes, and essential, emergency and security processes. This audit found all of these areas to be compliant with required standards</p>

		except the food service where improvements are required (link 1.3.13.1 and 1.3.13.5).
<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>The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and ongoing assessment includes gaining details of resident's beliefs and values. Care plans sampled demonstrated that interventions to support these are identified and evaluated. Care staff interviewed (four caregivers, one registered nurse (RN), one diversional therapist and one activities coordinator) could describe the procedures for maintaining confidentiality of resident information and employment agreements bind staff to retaining confidentiality of client information. The service's philosophy focuses on residents' right to respect, privacy and security is implemented in practice. There is a policy that covers abuse and neglect and staff have completed abuse and neglect training. During the visit, staff demonstrated gaining permission prior to entering resident private areas. Interviews with one family member identified that caregivers always respect residents' privacy.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy in place, information on which is included at the time of admission. A site-specific introduction to the psychogeriatric unit booklet provides information for family, friends and visitors visiting the facility. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Fifteen incident/accident forms were reviewed. The form includes a section to record family notification. All fifteen incident/accident forms indicated family are informed. One relative interviewed (no other relatives visited during the audit and no residents were competent to be interviewed) confirmed they are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Dementia Care NZ Limited (DCNZ) is the parent company under which Millvale House Miramar has been run since October 2011. Millvale House Miramar provides psychogeriatric level care and rest home level care for up to 26 residents with 21 residents receiving psychogeriatric level care in the home on the day of audit, and one rest home level care resident. This included one resident on a mental health (independent) contract and one resident on an ACC funded contract, both receiving psychogeriatric level care. All other residents were on the aged residential related care (ARRC) contract.</p> <p>DCNZ operates nine aged care facilities throughout NZ providing rest home, hospital, medical, dementia and psychogeriatric level care. There is a corporate structure in place, which includes the two directors and a governance team of managers and coordinators supports them. There is a regional clinical manager North Island and a regional clinical manager South Island. There is a 2016 – 2017 business plan in place for all facilities.</p>

		<p>An operations manager and a clinical manager manage Millvale House Miramar daily. The operations manager reports directly to the general manager and the clinical manager reports directly to the regional clinical manager North Island. The operations manager has been in the role for six years. She has qualifications in nursing (overseas trained), and dementia care. The clinical manager (RN) is responsible for the clinical oversight of the service. The clinical manager has been in the position for two and a half years.</p> <p>The organisation holds an annual training day for all operations managers and all clinical managers. The operations manager and the clinical manager have each attended at least eight hours of education in the past 12 months.</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>	FA	<p>Dementia Care NZ Limited (DCNZ) is the parent company under which Millvale House Miramar has been run since October 2011. Millvale House Miramar provides psychogeriatric level care and rest home level care for up to 26 residents with 21 residents receiving psychogeriatric level care in the home on the day of audit, and one rest home level care resident. This included one resident on a mental health (independent) contract and one resident on an ACC funded contract, both receiving psychogeriatric level care. All other residents were on the aged residential related care (ARRC) contract.</p> <p>DCNZ operates nine aged care facilities throughout NZ providing rest home, hospital, medical, dementia and psychogeriatric level care. There is a corporate structure in place, which includes the two directors and a governance team of managers and coordinators supports them. There is a national clinical supported by a clinical director. There is a 2016 – 2017 business plan in place for all facilities.</p> <p>An operations manager and a clinical manager manage Millvale House Miramar daily. The operations manager reports directly to the operations management leader and the clinical manager reports directly to the national clinical manager. The operations manager has been in the role for five and half years. The clinical manager (RN) is responsible for the clinical oversight of the service. The clinical manager has been in the position for two and a half years.</p> <p>The organisation holds an annual training day for all operations managers and all clinical managers. The operations manager and the clinical manager have each attended at least eight hours of education in the past 12 months.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	FA	<p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Fifteen incident forms reviewed identified they were fully completed and followed-up appropriately by the RN. Minutes of the monthly quality meeting, health & safety meetings and RN/clinical meetings reflected a discussion of incidents/accidents and</p>

<p>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>		<p>actions taken.</p> <p>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. Four section 31 notifications were completed since the last audit. Notifications were for residents absconding in December 2015, November 2016 and May 2017.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Five staff files were reviewed (one registered nurse, one caregiver, one activities coordinator, the head cook and the cleaner). Job descriptions, reference checks, police checks and employment contracts were evident in all files reviewed. Performance appraisals were up-to-date. A copy of practising certificates was sighted for all registered nurses, and allied/medical staff.</p> <p>The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Four caregivers interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service. All five files reviewed showed evidence of orientation to roles with competency packages completed.</p> <p>Competency packages for registered nurses include (but not limited to), restraint minimisation and safe practice, first aid, ACE dementia series, delirium, syringe driver, medication, neurological conditions and leadership. The caregivers' competency package includes (but not limited to), restraint minimisation and safe practice, first aid, taking vital signs, safe medication administration, ACE programme and leadership. All staff also complete safe food handling, chemical safety, safe manual handling (hoist use), bi-cultural awareness and infection control.</p> <p>There is an in-service calendar currently being implemented for 2017. The annual training programme well exceeds eight hours annually and covers all required topics. Additionally, all caregivers are supported to complete the aged care education certificate core and dementia standards. The service provides regular staff training on the 'best friends' model of care.</p> <p>There are four registered nurses, two have completed interRAI training. There are 18 caregivers, 17 have completed the required dementia standards and one has not worked at the service for a year and is in the process of completing. The diversional therapist has completed the dementia standards.</p>
<p>Standard 1.2.8: Service Provider</p>	<p>FA</p>	<p>The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a registered nurse on duty in the home 24/7. Sufficient staff are rostered on to manage the care requirements of the residents. The operations manager works full-time and the clinical manager works three days</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>per week providing clinical administration and rostered registered nurse shifts.</p> <p>Staffing is as follows:</p> <p>AM shift: One registered nurse, two caregivers full shift, one caregiver until 1.30 pm and one caregiver until 1 pm.</p> <p>PM shift: One registered nurse, two caregivers from 3 pm to midnight, and two caregivers from 3 pm to 10 pm.</p> <p>Night shift: One registered nurse (11 pm to 7 am), one caregiver (midnight to 8 am).</p> <p>Activities staff: One x 10.30 am to 5.30 pm, one x 1.30pm to 5.30 pm x five days.</p> <p>There is a designated cleaning person who works 8 am to 1.30 pm. This person has been employed in a cleaning role for many years and their hours were increased to 5 ½ hours daily when Dementia Care New Zealand took over the operation of the facility.</p> <p>Interviews with staff and the one family member identified 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>	<p>FA</p>	<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 robotic rolls on delivery against the medication charts. Registered nurse's complete annual medication competencies and complete syringe driver competency.</p> <p>There were no self-medicating residents. There are no standing orders. All medications are stored safely. The medication fridge temperature is monitored. There are weekly oxygen and emergency medication checks. Eye drops are dated on opening.</p> <p>The service uses an electronic medication management system. Ten medication charts reviewed had photo identification and allergies noted. 'As required' medications had prescribed indications for use. The medication charts had been reviewed by the GP 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</p>	<p>PA Low</p>	<p>There is a kitchen service manual located in the kitchen, which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. There is one full-time cook and one part-time cook (who works weekends). Kitchen hands assist with the evening meal, supper and cleaning duties. All staff have attended food safety and hygiene, chemical safety, first aid and relevant in-service training. The kitchen is located within the psychogeriatric home and is locked via a combination lock so that only staff can access this area. There is a kitchenette in the dining areas where food is dished up to residents. Containers of food are transported in hot boxes to the kitchenette, where caregivers plate and serve the meals.</p> <p>The cook receives a nutritional assessment for each new resident but is not always notified of any changes, special diets or weight loss. Pureed and normal diets are provided. Resident likes and dislikes are known and alternative</p>

<p>component of service delivery.</p>		<p>foods are offered. Cultural and spiritual needs are met. There were adequate fluids sighted in the kitchenette fridges and supplement protein drinks are available. Staff can access the kitchen at any time to provide extra snacks or drinks when required. There is daily monitoring of hot food temperatures, fridge and freezer temperatures, dishwasher rinse temperatures and delivery temperatures for chilled/frozen goods. Not all perishable foods in the kitchen fridges and freezer are dated. The dry goods store has all goods sealed and labelled. Goods are rotated with the delivery of food items.</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 being provided is consistent with the needs of residents as demonstrated in the review of the care plans and discussion with caregivers, registered nurses, activity coordinator and management. The relative interviewed state their relative's needs are being met and they are notified promptly of any concerns. When a resident's condition changes, the RN initiates a GP or nurse specialist consultation. Progress notes record ongoing assessments of the resident's health status. Short-term care plans are used for short-term needs.</p> <p>A wound assessment and evaluation has been completed for one skin tear. There were no chronic wounds or pressure injuries on the day of audit. The service has access to the DHB wound nurse.</p> <p>Continence assessments including a urinary and bowel continence assessment are completed on admission and reviewed at least six-monthly or earlier if required.</p> <p>Pain assessments are completed for all residents with identified pain and requiring pain relief. Abbey pain assessments are completed for all residents unable to express pain. Monitoring charts in use include daily hygiene cares and bowel chart for every resident, continence monitoring, observations, blood glucose levels, behaviour monitoring, food and fluid intake, weight, restraint and wound monitoring as applicable.</p> <p>The dietitian visits regularly, completes any resident reviews due, and attends to any referrals received. The dietitian maintains progress notes in the integrated resident file.</p> <p>Challenging behaviour assessments are documented with amendments made to the care plan as required. The company has a non-violent crisis intervention coordinator who supports, advises and educates staff.</p>
<p>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</p>	<p>FA</p>	<p>The service employs a diversional therapist (DT) for 32 hours per week (10.30 am to 5.30 pm) Monday to Friday. She is supported by a part-time activity coordinator from 1.30 pm to 5.30 pm Monday to Friday and a weekend activity person. 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 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, movies and doll therapy. There are volunteers involved in the programme including: spiritual services, weekly pet therapy, singing and piano playing. Families are encouraged to join the activities and monthly</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>outings. The service has a wheelchair van.</p> <p>Recreational doll therapy has been successfully introduced. There is a visiting priest weekly. Entertainment is scheduled fortnightly. There is a van outing weekly for residents. The DT has a current first aid certificate. The activity staff all have current first aid certificates.</p> <p>Activity assessments, activity plan, 24-hour MDT care plan, progress notes and attendance charts are maintained.</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. 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. Activities were observed to be occurring in the three lounges simultaneously.</p> <p>The rest home resident is invited to attend group entertainment and outings as desired. The activity staff make daily contact and ensure the resident's recreational preferences are being met.</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>Initial care plans were evaluated by the RN within three weeks of admission in the files reviewed. Long-term 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 three-monthly MDT reviews. If unable to attend the enduring power of attorney (EPOA) receives an email copy of the MDT written review. Other health professionals are involved as appropriate, such as the physiotherapist and dietitian. Short-term care plans are reviewed as required and resolved or if an ongoing problem, added to the long-term care plan. There is at least a three-monthly review by the medical practitioner of the resident and their medications. Ongoing nursing evaluations occur daily and included within the progress notes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately</p>	<p>FA</p>	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. The file sample was extended to review referral documentation around the change in a resident's health including documentation in progress notes, GP visits, relative notification and transfer to hospital. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the needs assessment team. Currently there are no examples where a resident's condition has changed and required reassessment to a different level of care.</p>

facilitated, or provided to meet consumer choice/needs.		
<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 service has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. The facility displays a current building warrant of fitness, which expires in June 2017. Electrical equipment has been tested and tagged. Contractors are available 24/7 for essential services. Hot water temperatures are monitored weekly and are between 39 and 42 degrees Celsius (sighted). In January 2017, there was an issue when the water temperature in hand basins in two resident's rooms dropped to 36 degrees. This was resolved promptly. Residents can move freely inside and within the secure outside environments. There is a ramp to the outsides and the paths are maintained. There are open plan homely areas that are spacious and allow for the use of mobility equipment. There are two centralised lounges. There are outside areas that include seating and shade around the facility.</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>The service has in place policies and procedures for effective management of laundry and cleaning practices. This included (but is not limited to) collection of soiled laundry, linen processing and transporting. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. There is a sluice room for the disposal of soiled water or waste.</p> <p>There is a cleaning staff member who works 5.5 hours 6 days per week. Training records show the cleaner is well orientated to cleaning procedures and has received ongoing training around the appropriate and safe use of cleaning products.</p> <p>During a tour of the facility and throughout the day the service was noted to be very clean with no odours. All bathrooms have been renovated and were fresh and clean.</p> <p>It was noted that linen cupboards were well stocked with linen, a combination of some older and a large supply of new linen.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and</p>	FA	<p>There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR are included in the mandatory in-service programme. There is staff on duty with a current first aid certificate at all times. The facility has an approved fire evacuation plan and fire drills occur six-monthly. Smoke alarms, sprinkler system and exit signs were in place. Emergency lighting and cooking is available in the event of a power failure. There are two civil defence kits in the facility and sufficient stored water. Call bells are evident in resident's rooms, lounge areas and toilets/bathrooms. Not all residents are able to use call bells so regular checks of residents also occur. Three residents who can use the call bell had these within reach</p>

security situations.		when randomly checked during the audit. The facility is secured at night.
<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, 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>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with caregivers and nursing staff confirm their understanding of restraints and enablers. There were six residents assessed as requiring restraint and no residents using enablers on the day of audit.</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 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	The service uses the DCNZ dietitian approved menu and the cook was familiar with preparation requirements for special diets. When a resident is admitted a form outlining likes, dislikes and allergies is provided to the kitchen. However, when a resident’s dietary needs change the cook is sometimes, but not always, informally notified of this. Care staff plate food and serve residents and those interviewed were aware of individual resident requirements so the risk is assessed as low.	There is no formal communication process to inform the cook of changes to dietary needs, weight loss or instructions from the dietitian.	Ensure that a formal process is developed to ensure that kitchen staff are aware of the dietary needs of residents. 60 days
Criterion 1.3.13.5 All aspects of food procurement, production,	PA Low	The kitchen staff are trained in food safety and the cook interviewed described safe practices to ensure the food supplied is safe, including regular delivery of supplies and monitoring of fridge and freezer temperatures. However, not all food in the fridge was stored in line with	There were items of food in the refrigerator which were not dated.	Ensure all stored food is dated.

preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		good practice.		90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.