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

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Admatha Dementia Care Limited

**Premises audited:** Admatha Dementia Care||Admatha Lodge

**Services audited:** Hospital services - Psychogeriatric services; Dementia care

**Dates of audit:** Start date: 23 October 2018 End date: 23 October 2018

**Proposed changes to current services (if any):** Two resident rooms in Admatha Home have been converted into an office reducing the bed numbers to 55.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 54

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

## General overview of the audit

Admatha Dementia Care is part of the Dementia Care New Zealand (DCNZ) group, which is privately owned. The service is certified to provide psychogeriatric level care and dementia level of care for up to 55 residents. On the day of the audit, there were 54 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents’ and staff files, observations, and interviews with residents, relatives, general practitioner, management and staff. Relatives commented positively on the standard of care and services provided at Admatha Dementia Care.

The facility is managed and operated by an operations manager who has been in the role for three years and a clinical manager who has been in the position for nine months and has worked at DCNZ for nine years. The management team are supported by the organisational operations management leader, national clinical manager, quality systems manager, company clinical director, company educator/psychiatric RN and directors.

The one shortfall from their previous certification has been addressed regarding initial assessments.

The service has been awarded a continuous improvement relating to the reduction of infection rates.

## Consumer rights

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

The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. Family members are informed in a timely manner when their family members health status changes. A site-specific introduction to the dementia/psychogeriatric 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.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The quality and risk programme includes a variety of quality improvement initiatives which are generated from meetings, resident, family and staff feedback and through the internal audit systems. Admatha Dementia Care has a current business and quality plan to support quality and risk management at each facility. Admatha Dementia Care implements an internal audit programme and collates data for comparisons against other Dementia Care NZ facilities. Incidents and accidents are appropriately managed. The service has a documented annual training plan. The service has an orientation programme in place. Staff requirements are determined using an organisation service level/skill mix process and documented. There is a documented rationale for staffing. Staffing rosters indicate there is suitable staff on duty to care for residents.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

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 and included behaviour management and activity plans. Relatives interviewed confirmed they were involved in the care planning and review process. There is at least a three-monthly resident review by the medical practitioner and psychogeriatrician as required. The activity programme includes meaningful activities that meet the recreational and interests of each resident. Individual activity plans have been developed in consultation with resident/family. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. There are regular visits and support provided by the community mental health team and psychogeriatrician. The food services are provided from the main kitchen for the lodge and delivered in hot boxes to the dementia home kitchenette. Residents’ individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period. There is dietitian review and audit of the menus. All staff have been trained in food safety and hygiene.

## Safe and appropriate environment

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| 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. |

Both buildings (Admatha Home and Lodge) have current building warrants of fitness.

## Restraint minimisation and safe practice

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| 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 policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. On the day of the audit there were nine residents with restraints and there were no residents with enablers. Staff regularly receive education and training on restraint minimisation.

## Infection prevention and control

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

The infection control 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.

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| **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** | 1 | 15 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 37 | 0 | 0 | 0 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | 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. An established complaints register is included on an access database. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response. Six complaints (five in 2018 and one in 2017) received since the last audit 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 reviewed were documented as resolved.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an open disclosure policy in place, information on which is included at the time of admission. A site-specific introduction to the dementia/psychogeriatric unit booklet provides information for family, friends and visitors to 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. Ten incidents/accidents forms were reviewed for September 2018. All incident/accident forms reviewed indicate family are informed. Three relatives (two dementia and one psychogeriatric level) interviewed confirmed they are notified of any changes in their family member’s health status. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Admatha Dementia Care provides care for up to 55 residents requiring hospital psychogeriatric care and dementia specific rest home care. Two resident rooms in Admatha Home have been converted into an office, reducing the bed numbers to 55. There are two units in separate buildings. One unit (Admatha Lodge) provides care for up to 25 residents requiring psychogeriatric care with 24 residents on the day of audit, including two younger residents on ‘Like and Interest’ contract. The other unit (Admatha Home) provides care for up to 30 residents requiring dementia level care. There were 30 residents on the day of audit, including one resident on respite care, one resident on a mental health contract and one resident on a ‘Like and Interest’ contract. All other residents are under the aged related residential care (ARRC) contract. Dementia Care NZ has a corporate structure in place, which includes two directors and a governance team of managers and coordinators. The operations management leader and national clinical manager support the operations manager and the clinical manager respectively. The vision and values of the organisation underpin the philosophy of the service. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. There is a strategic plan for 2018-2021 and a business plan for 2018-2019 in place for all DCNZ facilities. The 2017 organisational goals have been reviewed by the governance team, company clinical director, quality systems manager and company educator/psychiatric RN. An operations manager and a clinical manager oversee Admatha Dementia Care on a daily basis. The operations manager reports directly to the operations management leader and the clinical manager reports directly to the national clinical manager who reports to the clinical director. The operations manager has been in the role for three years. The clinical manager is responsible for the clinical oversight of the service and has been in the position for nine months and has worked at DCNZ for nine years. An organisational operations management leader, national clinical manager, quality systems manager, company clinical director, company educator/psychiatric RN and directors provide support to the team at Admatha Dementia Care. At the time of the audit the company director, national clinical manager and quality systems manager were present.The operations manager and the clinical manager have each attended at least eight hours of education in the past 12 months in relation to their respective roles. The organisation holds an annual training day for all operations managers and all clinical managers.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation-wide quality and risk management plan describes objectives, management controls and assigned responsibility. 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. Meeting minutes are maintained, and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Quality improvement (QI) reports are provided at the monthly quality meeting. Staff interviewed confirmed involvement and feedback around the quality management system. Data is collected on complaints, accidents, incidents, infection control and restraint use. Benchmarking with other DCNZ facilities occurs on data collected. The service has policies and procedures to support service delivery. Document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The internal audit schedule for 2018 is being completed. Areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. The service has an implemented health and safety management system. There are risk management, and health and safety policies and procedures in place including accident and hazard management. The organisation’s annual resident/relative satisfaction survey was completed in January 2018. Overall results report that residents and relatives are satisfied with the service. Falls prevention strategies are in place that includes assessment of risk, medication review, assessments with physiotherapy input and exercises/physical activities. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.  |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | 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. Ten incident forms reviewed identified they were completed and followed up appropriately by the RN. Neurological observations were completed for three resident fall incidents reviewed with a suspected injury to the head. Minutes of the monthly quality meeting, health & safety meetings and RN/clinical meetings reflected a discussion of incidents/accidents and actions taken. 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. There have been 12 section 31 notifications completed since the last audit. Nine were completed for missing residents in January, April, August (3x), October (3x) 2018 and in January 2017. Two resident deaths in March and October 2018 and one notification for the new clinical manager starting in January 2018. Corrective actions have been developed and implemented for two residents that related to six of the nine missing person notifications. An outbreak of sapovirus in July 2017 was also notified to the public health authorities.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resources policies to support recruitment practices. Five staff files sampled (one operations manager, one clinical manager, one RN, one caregiver and one house manager) contained all relevant employment documentation. Current practising certificates were sighted for the RNs and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. There is an education planner in place for 2018 that covers compulsory education requirements and includes programmes designed and implemented by the service. There are 31 caregivers employed across the dementia and psychogeriatric units. Twenty-nine have completed the required dementia unit standards. Two caregivers are in the process of completing and all have been employed for less than 18 months. The "Best Friends Approach to Dementia Care" programme is designed to support caregivers and RNs to adapt a best friend approach to residents with dementia. Regular “Best Friends Approach to Dementia Care” (putting yourself in their shoes) training is carried out for all staff. There are five RNs and all five have completed interRAI training. The clinical manager has also completed interRAI training. Clinical staff complete competencies relevant to their role.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, including for dementia and psychogeriatric level care. Rosters are published for staff. The operations manager and the clinical manager are on-site full time and available afterhours for any operational or clinical issues respectively. The clinical manager spends two days as the RN at Admatha Home and three days as the clinical manager for Admatha Home and Admatha Lodge. There is a RN on duty 24/7 in Admatha Lodge. Staff and relatives interviewed stated that there are sufficient staff numbers. At Admatha Lodge (psychogeriatric) there are 24 residents in total, 13 of 13 residents in the Amour wing and 11 of 12 residents in the Mon-Ami wing. There is one RN on the morning and afternoon shift, and on the night shift. In the Amour wing the RN is supported by two caregivers, (one full shift and one short shift) one of which is home manager on the morning shift. Two caregivers (one full and one short shift)on the afternoon shift and one caregiver on the night shift. In the Mon-Ami wing there are two caregivers (both full shifts - one of which is home manager on the morning shift, two caregivers (one full and one short shift) on the afternoon shift and one on the night shift. The caregivers are supported by one diversional therapist (full shift) and one home assistant on the morning and afternoon shifts.At Admatha Home (dementia rest home unit) there are 30 residents in total, 17 of 17 residents in the Tai wing and 13 of 13 residents in the Awa wing. There is one RN on the morning shift (including the clinical manager). The RN is supported by two caregivers (one home manager) on the morning shift. Two caregivers (one full and one short shift) one diversional therapist (short shift) on the afternoon shift and one caregiver on the night shift in the Tai wing. In Awa wing there is one caregiver on the morning shift, one caregiver and one diversional therapist on the afternoon shifts and one caregiver on the night shift. The caregivers are supported by one home assistant on the morning and afternoon shifts. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policies and procedures comply with medication legislation and guidelines. All medications and medication trolleys are stored safely in the locked nurses’ station in the home (dementia care) and the Lodge (psychogeriatric care). All staff that administer medicines are competent and have received medication management training. Registered nurses only administer medications in the psychogeriatric units. Caregivers who have completed medication competencies administer medications in the dementia home. Medication robotic rolls are delivered fortnightly and checked in by an RN against the medication chart on the electronic medication system. All medication is prescribed for the person. Expiry dates of ‘as required’ medications are checked weekly. All eye drops are dated on opening. A bulk supply order is held in the Lodge (hospital level) and expiry dates checked monthly. The medication fridge temperatures are checked daily and within the acceptable range. There were no residents self-medicating. Ten medication charts (four psychogeriatric and six dementia) were viewed on the electronic medication system. All prescribing, and administration met legislative requirements. The GP reviews the medication charts three monthly. The psychogeriatric service reviews the use of antipsychotic medications on GP request.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The main kitchen is in the Lodge and has keypad entry. There are cooks on duty from 6.45 am to 5.15 pm daily. Cooks have completed food safety. All meals are prepared and cooked in the main kitchen. The four-week menu is reviewed by a dietitian. The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Resident likes and dislikes are known, and alternative foods are offered. Special diets accommodated are gluten free, soft and pureed. Containers of food are delivered in hot boxes to the home where meals are served from the dining room kitchenette. The kitchen is adjacent to the dining room in the Lodge. There are nutritious snacks available 24 hours in all kitchenettes. There is daily monitoring of end-cooked food temperatures, fridge and freezer temperatures, dishwasher rinse temperatures and inward goods. A cleaning schedule is maintained. The dry goods 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. The food control plan was submitted to the council 14 March 2018. Feedback is received from family members and through annual surveys.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Registered nurses (RNs) and caregivers, follow the care plan and report progress against the care plan each shift at each handover. When a resident’s condition changes the RN initiates a GP or nurse specialist consultation. There is specialist input into the resident’s care in the psychogeriatric unit as required. The community mental health/psychiatric nurses maintain a close liaison with the clinical manager/RN, GP and the psychogeriatrician based at the DHB. There is evidence in the medical notes of GP communication with the psychogeriatrician in regard to medication review. Staff have access to sufficient medical supplies (eg, 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. There were no wounds in the dementia unit and four residents with wounds in the psychogeriatric unit, which included one chronic ulcer and two pressure injuries (one stage three heel facility acquired and one stage two heel on admission). All wounds have wound assessments and have been reviewed within the documented timeframes. The RNs also have access to specialist nursing wound care advice through the DHB. Behaviours that challenge have been well identified through the assessment process in the residents’ files reviewed. Twenty-four-hour multidisciplinary care plans describe the resident’s usual signs of wellness, changes and triggers, interventions and de-escalation techniques (including activities), for the management of challenging behaviours. Behaviour charts and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours. Daily forms are completed for walking residents at risk that evidence 15 minutes physical checks on the whereabouts of the residents. The form also includes the clothing the resident is wearing on the day. Monitoring forms include pain, behaviours, observations, neurological observations blood sugar levels, weight, re-positioning charts, food and fluid and 24-hour hourly checks.  |
| Standard 1.3.7: Planned ActivitiesWhere 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. | FA | A team of two diversional therapists in training and an activities coordinator provide an afternoon activity programme in each of the homes (dementia level and two psychogeriatric level). In the mornings, the activity team are involved in assisting with activities of daily living such as breakfast. There is an afternoon programme, seven days a week for each home, however this is flexible to meet the resident needs. Informal activities occur throughout the 24-hour period as required with caregivers also involved in one-on-one activities. There are resources available to staff for activities. The programme for the psychogeriatric and dementia residents is focused on individual and small group activities that are meaningful, including household tasks, reminiscing and sensory activities, baking, garden walks, flower arranging, arts and crafts, water therapy, games, music and movies. There is a weekly cooking club and monthly men’s club. There are weekly outings for drives and places of interest, including community events as applicable. Entertainment, dog therapy and church services are scheduled regularly in each home. 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. 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. Assessment for younger persons include past and present interests which are reflected in individual activity plans. They are invited to attend activities and included in all van outings, garden walks and exercise groups. Resident and family meetings are held. Relatives interviewed confirmed their satisfaction around activities offered.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Files reviewed (for all long-term residents) demonstrated that the long-term care plans were evaluated at least six monthly (or earlier if there was a change in health status). Changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem was ongoing, as sighted in resident files reviewed. Where progress is different from expected, the service updated changes in the long-term care plan. The GP reviewed the resident at least three monthly.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The rest home building has a building warrant of fitness that expires 2 April 2019. The Lodge has a building warrant of fitness that expires 1 June 2019. There is a reactive and planned maintenance programme in place. The gardens and grounds at the rest home have been re-landscaped, including new decking and seating. The external fencing has been re-panelled and an area under development for a children’s playground. Two resident rooms in Admatha Home have been converted into an office reducing, the bed numbers to 55.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | CI | There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections for the dementia and psychogeriatric units is entered separately into a monthly infection summary. Surveillance results are reported to the infection control committee and staff and meeting minutes are made available to read. The data has been monitored and evaluated at organisational level. Care staff interviewed were aware of infection rates. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities. The service has continued to remain below the industry indicators for urinary tract infections in the home and lodge. An outbreak of sapovirus in July 2017 within the dementia home, was appropriately managed. Notification to the DHB and documentation was sighted.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the caregiver and nursing staff confirmed their understanding of restraints and enablers. A register is maintained by the restraint coordinator/RN. On the day of the audit there were nine residents with restraints (six H-belt and three bedrails) and there were no residents with enablers. An assessment for restraint use and consent form were evidenced in the three resident files with restraints reviewed. Staff regularly receive education and training on restraint minimisation, last occurring in August 2018.  |

# 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.

|  |
| --- |
| No data to display |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 3.5.7Results 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. | CI | All infections are reported, and data is collated and analysed for trends. The service has continued to remain below the industry indicators for urinary tract infections in the dementia home and lodge. | The service has continued to monitor compliance of infection control practice through regular staff education, including orientation for new staff, internal audits, surveillance of residents, wound management, kitchen and laundry/housekeeping areas. Care staff are informed daily at shift handovers of any suspected infections or residents at risk. Care staff interviewed were knowledgeable around infection control, resident hygiene and toileting for its dependent residents. Analysis of monthly data for UTIs in the dementia care and psychogeriatric care units evidence the average year-to-date rates are below the NZ industry average standard rate of 1.51 annually. The average year-to-date average for dementia care is 0.97 and for psychogeriatric care 0.82. The service has maintained a low rate of infections and retains a continuous improvement rating.  |

End of the report.