

# Avonlea Dementia Care Limited - Avonlea Dementia Care

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## 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:

<b>Legal entity:</b>	Avonlea Dementia Care Limited
<b>Premises audited:</b>	Avonlea Dementia Care
<b>Services audited:</b>	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
<b>Dates of audit:</b>	Start date: 13 February 2019      End date: 13 February 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	53

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
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. The service is divided into six smaller home-like care units, one hospital unit, one psychogeriatric care unit and four dementia care units. Occupancy on the days of audit was 53 residents.

This unannounced surveillance audit was conducted against a subset of 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, General Practitioner, management and staff.

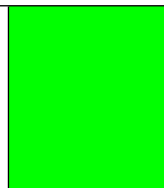
An operations manager and clinical manager, manage the service on a day-to-day basis. The management team are experienced with dementia level care. They are supported by an organisational management team from DCNZ. The families interviewed all spoke positively about the care and support provided.

The service has addressed the two previous certification shortfalls around assessments and implementation of care.

This audit has identified one improvement required around care plan interventions.

## Consumer rights

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

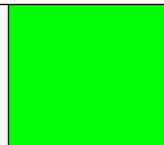


Standards applicable to this service fully attained.

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

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.

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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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.

Medications are managed in line with current legislation and guidelines.

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. Resident rooms are personalised. 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. 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). 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.
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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. 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)
<b>Standards</b>	0	16	0	1	0	0	0
<b>Criteria</b>	0	42	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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. Interviews with four relatives confirmed an understanding of the complaints process. There is an up-to-date online complaint register. There have been 11 complaints (verbal and written) received in 2018 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 November 2018 was sighted. The service is proactive around identifying opportunities for improvements from complaints received and corrective actions are routinely developed and implemented.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</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 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. Thirteen incidents/accidents forms were reviewed from across the service for February 2019. All incident/accident forms reviewed indicate family are informed. Four relatives (two hospital and two dementia) interviewed confirmed they are notified of any changes in their family member's health status. There were no residents able to be interviewed.</p>



conducive to effective communication.		
<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>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 53 residents.</p> <p>The service is divided into six smaller home environments. This includes an 11-bed psychogeriatric unit (occupancy 10 residents, all under the ARHSS contract), a 10-bed hospital unit (occupancy 9 residents all under the ARC contract), an 8-bed dementia unit including one dedicated respite bed (occupancy 7 residents, all under ARC contract), a 16-bed dementia unit (occupancy 11 residents, all under ARC contract) and two 10-bed dementia units (occupancy 7 and 9 residents, including one resident on a Close and Interest contract).</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. There is a strategic plan for 2018-2021 and a business plan for 2018-2019 in place for all DCNZ facilities. The 2018 organisational goals are in the process of being reviewed by the governance team. There are 2019 organisational and site-specific quality goals developed.</p> <p>The operations manager and clinical manager have had many years' experience with DCNZ and working with people with dementia. There are monthly quality reports which include benchmarking across DCNZ and monthly operations reports.</p> <p>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 Avonlea. The company director and quality systems manager were present for interview at audit.</p> <p>The operations manager and the clinical manager have each attended at least eight hours of education in the past 12 months in relation to their respective roles. The organisation holds an annual training day for all operations managers and all clinical managers.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management</p>	FA	<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 including follow up on corrective actions.</p> <p>Organisational policies meet all current requirements and are reviewed at head office. Staff have access to the policy manuals.</p> <p>Interviews with staff and review of meetings minutes confirmed that there is discussion about quality data/trends/corrective actions at various facility meetings including (but not limited to) monthly quality improvement</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>meetings and clinical meetings. Data is collected in relation to a variety of quality activities and a register is maintained of corrective actions identified through all quality activities. The internal audit programme continues to be implemented and all issues identified had corrective action plans and resolutions. Resident Event Analysis monthly meetings are completed. A 6-monthly analysis report and an annual analysis report reviews incidents and monitors progress to their objective of reducing falls by 25%.</p> <p>The service is proactive in developing and implementing quality initiatives.</p> <p>The following surveys were completed in 2018, restraint response survey (positive outcome with no required corrective actions), post admission survey (positive outcome with no required corrective actions), respite survey (positive outcome with one required corrective action), and welfare guardian survey with an overall outcome of 92%. Survey results are shared with staff and relatives.</p> <p>The service has a Health and Safety Committee which comprises of staff from across the service. All committee members have completed external health and safety education. 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. 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 fall.</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>	<p>FA</p>	<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 the resident event analysis meeting, quality and clinical meetings including actions to minimise recurrence. An RN conducts clinical follow-up of residents. Thirteen incident forms reviewed demonstrated that all appropriate clinical follow-up and investigation had occurred following incidents. Neurological observations were completed for two resident falls reviewed with a potential head injury. 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. An outbreak was reported April 2018 through public health.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<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</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>veracity. Current practising certificates were sighted. Six staff files were reviewed (two registered nurses, two caregivers, one home assistant, and one cook) and there was evidence that reference checks and police vetting were completed before employment. Annual staff appraisals were evident in all staff files reviewed for those who have been with the service over twelve months.</p> <p>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>More than eight hours of staff development or in-service education has been provided annually. The in-service education programme for 2018 has been completed and the plan for 2019 is being implemented. Best Friends training and walking in another’s shoes workshops are attended by staff. There is an organisational education coordinator that assists with supporting staff through training</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). All RNs have completed first aid training.</p> <p>There are 33 caregivers who work in the hospital, dementia and psychogeriatric units. Thirty caregivers have completed the required dementia unit education modules. One caregiver is in the process of completing national dementia unit modules. There are two caregivers (employed in October 2018) that are yet to commence.</p> <p>Seven of nine 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 morning, afternoon and night shift seven days per week in both the hospital unit and psychogeriatric unit. The RN in the hospital and PG unit oversees the dementia units.</p> <p>There are two separate roles. Caregivers undertake hands-on caregiving and resident care. Home assistants undertake housekeeping duties.</p> <p>Aroha household - PG (10 residents) – There is one RN across all three shifts. Morning shift: One caregiver 7am – 3pm, one HA 8am – 12.30pm. Afternoon shift: one caregiver 3pm – 11pm. one HA 4.30pm – 8pm. A DT – 10am –</p>

		<p>1pm.</p> <p>Ofa household- dementia (7 residents) – caregivers on morning 7- 3pm, and 7 – 12.30pm, caregivers on afternoon shift 3pm – 12am, 4.30pm – 8pm. DT 1.30pm – 4.30pm. Night shift: One caregiver on night from 12am – 6.45am and then assists in Aroha from 6.45am to 8am.</p> <p>Rudo household - dementia (9 residents) – Morning shift: one caregiver 7am – 3pm, one HA 8am – 1.30pm. Afternoon shift: one caregiver 3pm – 11pm, one HA 4.30pm – 8pm. A DT – 10am – 1pm. Night shift: One HA 12am – 8am.</p> <p>Mahal household -hospital (9 residents) – There is one RN across all three shifts. Morning shift: One caregiver 7am – 3pm, one HA 8am – 12.30pm. Afternoon shift: one caregiver 3pm – 11pm, one HA 4.30pm – 8pm. A DT – 10am – 1pm.</p> <p>Awhi Whanau household -dementia (7 residents) - Morning shift: one caregiver 7am – 3pm, one HA 8am – 3pm. Afternoon shift: One caregiver 3pm – 11pm, one HA 4.30pm – 8pm. Night shift: One HA 12am – 8am. A DT – 1.30pm – 4.30pm.</p> <p>Hoa Pumau household- dementia (11 residents) - Morning shift: two caregivers 7am – 3pm. Afternoon shift: one caregiver 3pm – 12am, one caregiver 4.30pm – 8pm. Night shift: One caregiver 12am – 6.45am and 6.45am – 8am in Mahal A DT – 1.30pm – 4.30pm.</p> <p>Staff are visible and available to meet resident’s needs, as reported by family members interviewed. Staff interviewed stated that overall the staffing levels are satisfactory.</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>Twelve electronic medication charts were reviewed (eight dementia, two psychogeriatric, and two hospital). The medication management system includes policy and procedures that follows recognised standards and guidelines for safe medicine management practice. Two registered nurses check medications on delivery against the electronic medication charts. Registered nurses and medication competent caregivers administer medications and they have completed annual medication competencies and education.</p> <p>All electronic medicine charts had photo identification, allergies documented and evidence of a three-monthly GP review. All medications charts were clear and had accurate information on drug administration to include reason for use. There were no residents on a sliding scale of insulin on the day of audit. There were no gaps in the administration records. The previous audit finding has been addressed.</p> <p>As required medications were appropriately prescribed and documented indications for use. Controlled drugs are stored in the hospital unit, one RN and one medicine competent staff check and complete the administration records for controlled drugs, there are weekly checks performed. There were no expired drugs, drugs no longer in use are returned to the pharmacy on a weekly basis.</p>

		There were no self-medicating residents. The standing orders meet legislative requirements. All medications are stored safely. The medication fridge temperature is monitored and recorded on a daily basis.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>A food control plan is in place expiring 16 April 2019. All meals at Avonlea are prepared and cooked on-site in a fully equipped kitchen. There is a four-weekly summer and winter DCNZ menu which has been reviewed and approved by a dietitian. 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>A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines.</p> <p>Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. 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. Resident weights are recorded at least monthly.</p> <p>Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Family members interviewed were satisfied with the meals and confirm that alternative food choices are available. Snacks are available in each unit 24/7.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Food is stored correctly.</p> <p>All staff working in the kitchen have completed training in food safety and hygiene and chemical safety.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<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 did not always document interventions to meet the resident's assessed care needs.</p> <p>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. Staff interviewed were knowledgeable of the needs of the residents they care for, and can describe triggers, behaviour and diversion techniques used.</p> <p>Care plans were integrated. Physiotherapist assessment, management plans and dietitian assessment and plans</p>

		where reflected in the LTCPs.
<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 Nurse Maude service or the mental health nurses). If external medical advice is required, this will be actioned by the GPs. 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 psych-geriatrician in regard to medication review.</p> <p>Staff have access to sufficient medical supplies (e.g., dressings). There were three wounds currently being managed by the service. Each wound has an assessment, plan and evaluations recorded, which show progression or deterioration towards wound healing. There were no pressure injuries on the day of the audit. Registered nurses describe access if required to the Nurse Maude service, which covers specialist wound care and palliative cares.</p> <p>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>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>	FA	<p>A team of one diversional therapist, two trainee diversional therapists, and two activities coordinators, with participation from the operations manager, 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, reminiscing and sensory activities such as massage and foot spas, household tasks, baking, gardening, garden walks, games, music and movies. The dementia programmes provide activities of normal life for all residents including the residents under 65, such as cleaning, folding washing, stacking the dishwasher and the like if residents choose. There are regular singalongs, lots of reminiscing, and sensory activities such as food tasting and aromatherapy. Group activities are held within small groups of residents with similar interests such as knitting, cooking, scrapbooking or reading magazines.</p> <p>The hospital programme is similar to the psychogeriatric programme with more one on one activities such as massages, reading to residents and going for walks in the garden, movie afternoons, cooking club and board games. A men's group has been developed, this includes having blocks of wood available for sanding and painting, 'men's' magazines are available, puzzles with tractors, outdoor activities include soccer, and horseshoe throwing. Entertainment is scheduled regularly in each unit. There is a weekly van outing for residents. The activities staff</p>

		<p>have current first aid certificates. The service has a shared wheelchair van and at least two staff attend all van outings.</p> <p>The magic merlin dog therapy sessions continue. This has expanded with a variety of farm animals visiting and canine friends visit the facility on a regular basis. A memory garden in memory of all that was lost in the earthquakes, stones are painted in the winter, and placed in the garden in the springtime.</p> <p>The focus for 2019 is to re-introduce doll therapy which has been used successfully in the past and trial music and light therapy, as the service has identified a number of resident behaviours where clinical interventions have a limited outcome. This is still very much in its infancy period.</p> <p>Activity assessments, activity plan, 24-hour MDT care plan, progress notes and attendance charts are maintained. Team meetings and resident meetings are held on a regular basis. 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. Individual 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 long-term care plans have been evaluated six-monthly (or earlier if there was a change in health status). 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.</p> <p>Short-term care plans are completed for acute changes in care and added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service has updated changes in the long-term care plan in all but one file reviewed (link 1.3.5.2).</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>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 June 2019. A staff member provides general maintenance. There is a scheduled maintenance plan in place. Contractors are contacted when required. The Director oversee's 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. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors from each home. The 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</p>

		confirmed that there was adequate equipment to carry out the cares according to the residents' care plans.
<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>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 monthly quality, infection control and staff meetings. A six-monthly IC review analysis report is completed. Benchmarking occurs against other Dementia Care New Zealand facilities using the NZ indicators for safe aged care. 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. An outbreak in March 2018 was well managed to prevent spread across all households with an outbreak debrief meeting held April 2018.</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 seven residents using restraint (five t-belt and two 'arm restraints'). When a resident requires two staff members to gently hold their arms to calm the resident and allow another staff member to provide essential cares, this is documented as 'arm restraint' and is only used after a full restraint assessment, discussion with the family and involvement of the GP. Staff are trained in restraint and managing behaviours.</p>



## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Two files reviewed of residents in the psychogeriatric (PG) unit (one for behaviour only) 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, interventions and de-escalation techniques (including activities), for the management of challenging behaviours.</p>	<p>(i) One hospital level whose condition recently deteriorated, the care plan interventions had not been updated to reflect the current needs.</p> <p>(ii) Unsuitable interventions were included in the printed care plans for a dementia and psychogeriatric resident.</p>	<p>(i) Ensure all care plans are updated to reflect current needs of residents.</p> <p>(ii) Ensure all interventions are relevant to individual residents.</p>

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

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

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

If, instead of a table, 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
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End of the report.