

Millvale House Waikanae Limited - Millvale House Waikanae

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 Waikanae Limited
Premises audited:	Millvale House Waikanae
Services audited:	Hospital services - Psychogeriatric services
Dates of audit:	Start date: 9 March 2020 End date: 10 March 2020
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:	30

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
	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

Dementia Care New Zealand Ltd is the parent company of Millvale Waikanae. The service provides psychogeriatric level care for up to 30 residents. There were 30 residents on the day of audit.

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 family, management, staff and the general practitioner.

A facility manager/clinical manager and operations coordinator are responsible for the daily clinical and non-clinical operations of the facility.

The service has continued to analyse data and implement quality action plans for reduction of falls and urinary tract infections.

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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Information about the Code of Rights and complaints process is readily available to residents and families. A site-specific introduction to the dementia home booklet provides information for family, friends and visitors to the facility. There is a regular support group for families. Newsletters keep families informed on the service. Family are involved in the resident care plans and evaluations. Complaints processes are implemented, and complaints and concerns are actively managed and well documented. A complaints register is maintained.

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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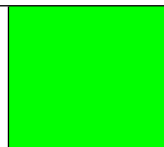
Dementia Care NZ has an established clinical governance group. The service has a well-established quality and risk management system. The quality system includes surveys, internal audits, meetings for staff and family and analyses of quality data. Incidents/accidents are documented. Reporting of incidents occurs and has been monitored with action taken on trends to improve service delivery.

Human resources policies and procedures were implemented. A comprehensive orientation programme provides new staff with relevant information for safe work practice. There is a comprehensive in-service programme in place, including specific training around “Best Friends Approach to Dementia Care” and specific behaviour management training. The service provides staff with a confidential counselling service.

Staff requirements are determined using a documented organisation service level/skill mix process.

Continuum of service delivery

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



Standards applicable to this service fully attained.

Care plans are developed by registered nurses and are reviewed by the multidisciplinary team. Families are involved in the development and review of the care plan. InterRAI assessments are linked into the long-term care plan. Six monthly multidisciplinary team evaluations occur in consultation with family.

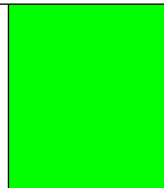
The multidisciplinary team including the diversional therapist develop a programme to meet the recreational needs and preferences of residents. There is a flexible and resident-focused activity plan over seven days a week in the two psychogeriatric homes. Individual activity plans are developed in consultation with family.

All medication charts on the electronic system have current identification photos and special instructions for the administration/crushing of medications. The GP reviews the residents' medication at least three-monthly.

The meals are prepared and cooked on site. There are nutritious snacks available 24 hours. A contracted dietitian has reviewed the menu and reviews resident nutritional status and needs 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.

The building has a current building warrant of fitness. There is reactive and planned maintenance scheduled. The gardens and grounds are well maintained. Residents in the psychogeriatric homes are able to move freely inside and within their secure environment.

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 three residents using restraints and no residents utilising enablers. 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 and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. 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. There have been no outbreaks.

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	16	0	0	0	0	0
Criteria	1	40	0	0	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 in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. Complaints information is available at the entrance and information is provided to relatives at entry. Complaints/compliments forms are available at the front entrance.</p> <p>There is an up-to-date complaint register on an access database format. The database register includes a logging system, complainant, name, dates, investigation, findings, outcome and response. The register identifies if the complaint has been resolved or not and the complainant is offered independent advocacy. There were six complaints in 2018 including one complaint to Consumer NZ which was referred back to the DHB. The complaint regarding staffing levels, mealtimes, caregiver duties and activities was investigated by the Clinical Director for DCNZ and a written response forwarded to the DHB. The complaint was closed without any further action required.</p> <p>In 2019, the DHB received a complaint around incontinence products found in the grounds. The complaint was investigated by the service to the satisfaction of the complainant. A tour of the facility grounds on the days of audit identified the garden and grounds were free of litter. Procedures are in place to prevent the incident from reoccurring and to minimise odour in the facility.</p> <p>There has been one complaint in 2020 regarding a resident's personal belongings which has been resolved. Complaints have been acknowledged and managed in line with the Code timeframes.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy in place, information on which is included at the time of admission. A site-specific introduction to the psychogeriatric service is described in a booklet and provides information for family, friends and visitors to the facility. Six accidents/incidents for the month of October 2019 were reviewed and evidenced EPOA/family notification. Two relatives interviewed confirmed they are notified of any changes in their family member's health status and they were welcomed when visiting. There are family support group meetings held on site three monthly with an advocacy support service. Families have contact details for the dementia support group. Regular newsletters keep families updated on facility matters, staffing, health and safety and infection control information and survey results.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Dementia Care New Zealand Limited (DCNZ) is the parent company under which Millvale Waikanae operates. Millvale Waikanae provides psychogeriatric level of care for up to 30 residents across two 15 bed homes – Tui and Kereru. On the day of audit, there were 30 psychogeriatric residents including four residents under the long-term support - chronic health condition funding (LTS-CHC). The service receives level 2 funding for five residents.</p> <p>The facility /clinical manager (RN) for Millvale Waikanae is also the acting facility /clinical manager for another 18-bed DCNZ facility in Levin. She works five days per fortnight for each facility and on call duties. She is supported by a part-time operations coordinator (non-clinical) who is responsible for the daily non-clinical operations for the facility. There is a senior RN (2IC) when the clinical manager is at Levin. The management team are supported by a national clinical manager, national clinical advisor, quality improvement manager, national educator and supportive owner/directors.</p> <p>There is an overall DCNZ strategic business plan for 2019-2020 that includes the vision, values and philosophy of care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. The 2019 organisational goals have been reviewed by the governance team. Millvale Waikanae has a site-specific quality plan that includes health and safety objectives, improving the pain management process and increasing pressure injury awareness.</p> <p>The operations coordinator has been in the role for a year and responsible for non-clinical services. She has attended a two-day DCNZ conference for operation coordinators. The facility/clinical manager (RN) has been in the role since September 2019 and has completed health and safety induction, clinical manager orientation and is registered to commence mental health and addiction papers in August 2020. HealthCERT and DHB have been notified of changes in clinical management positions.</p>
<p>Standard 1.2.3: Quality And Risk</p>	<p>FA</p>	<p>The organisation-wide risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the monthly quality</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>improvement meetings. The facility manager/clinical manager (RN) and operations coordinator log and monitor all quality data. Meeting minutes are maintained and staff are required to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Staff receive clinical and non-clinical quality bulletins which are a summary of quality data reports. Facility meeting minutes document discussion around infection control, health and safety, complaints/concerns and audit outcomes. Staff interviewed confirmed involvement and feedback around the quality management system.</p> <p>Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2019 has been completed and commenced for 2020. Areas of non-compliance identified at audits have a quality improvement raised. Corrective action plans developed had been signed as completed. Benchmarking with other DCNZ facilities occurs on data collected.</p> <p>Surveys are completed including respite care follow-up survey, six weeks post admission survey and EPOA surveys. The 2019 survey had a positive response around care and respect, notification of health changes and the family support group service offered for relatives.</p> <p>The service has policies and procedures to support service delivery that reflects best practice. New and reviewed policies are set down by head office. Staff are informed of new/reviewed policies. There is a current hard copy of policies in the nurses' station and they are available on the server.</p> <p>The service has an implemented health and safety management system. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. There are site-specific health and safety objectives. An RN is the health and safety officer and has been in the role eight months. She has completed an online course and enrolled to attend a health and safety course. The health and safety committee meet monthly and the meeting minutes are available to staff. All new staff complete a health and safety induction. Reported hazards are reviewed and added to the hazard register if unable to be eliminated. Progress to meeting the objective is evaluated through the monthly H&S meetings.</p> <p>Falls prevention strategies are in place that include assessment of risk; medication review; assessments with physiotherapy input; exercises/physical activities; training for staff on detection of falls risk; and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. There continues to be a downward trend for falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<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. There is a monthly resident event analysis meeting where all incidents/accidents are analysed for trends and preventative measures. The meeting minutes are available to staff. Six incident/accident forms reviewed identified they were fully completed and followed up appropriately by the RN. Benchmarking occurs with other DCNZ facilities.</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Discussions with the management team confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been two section 31s, one for a resident with positive campylobacter virus and one in May 2018 when the call bell system was not functioning for three days.</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>There are human resources policies to support recruitment practices. A register of practising certificates is maintained for registered nurse, GPs and allied health professionals involved with the service. Five staff files (two RNs, two caregivers and one diversional therapist) were reviewed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Annual performance appraisals had been completed annually.</p> <p>There is an annual education plan that has been completed for 2019 and commenced for 2020. Education provided meets the requirements of the ARHSS contract. The national educator (psychiatric nurse) visits the site regularly and provides specific education around challenging behaviours, de-escalation and disengagement and best friends approach to care. Clinical education is also provided by the national clinical manager and RNs. The physiotherapist provides training on safe manual handling for all new staff and annually thereafter. Repeat education sessions are offered and staff complete competencies if unable to attend education sessions. Competency packages include (but not limited to) restraint minimisation, medication, de-escalation and disengagement, fire safety, advocacy, abuse and neglect, food safety and infection control.</p> <p>There are four registered nurses. The acting facility/clinical manager is interRAI trained and there is one RN enrolled to attend interRAI training. There are 17 caregivers who work in the psychogeriatric homes. Fifteen caregivers have dementia standards, one caregiver is currently progressing through the standards and one caregiver was employed in November 2019. The national educator is a Careerforce assessor.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</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 24/7 to cover both homes within the facility. The facility/clinical manager was allocated two RN shifts per week prior to taking on the acting facility /clinical manager role at another DCNZ facility. Over a two-week roster there were three days where RNs worked 12-hour shifts which are rotated between the RNs. Sufficient staff are rostered on to manage the care requirements of the residents.</p> <p>The facility/clinical manager (RN) is on site five days per fortnight. The part-time operations coordinator works 12 hours per week spread across three days a week. There is a weekend manager (senior caregiver).</p>

<p>qualified/skilled and/or experienced service providers.</p>		<p>There is a rostered RN 24/7 including the 2IC when the CM is not onsite.</p> <p>Tui home (15 residents): AM shift: Two caregivers – 7 am – 3 pm and one home assistant 8 am – 1 pm PM shift One caregiver – 3 pm – 12 midnight, one caregiver 4 pm – 9 pm and one home assistant 3 pm – 10 pm Night shift: One caregiver - 12 midnight to 8 am</p> <p>Kereru home (15 residents); AM shift: Two caregivers – 7 am – 3 pm and one home assistant 8 am – 1 pm PM shift: One caregiver – 3 pm – 12 midnight, one caregiver 4 pm – 9 pm and one home assistant 3 pm – 10 pm Night shift: One home assistant</p> <p>The home assistant role is housekeeping and laundry.</p> <p>There is one DT and one activity coordinator who provide activities across seven days.</p> <p>Currently there are five residents with level 2 funding for an hour each day. The hour for the residents is allocated to the time of day where the resident is requiring one on one time such as risk of falls or behaviours. The caregivers are additional to the roster.</p> <p>Interviews staff and family members 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>Medication policies and procedures meet legislative requirements. The RNs administer medications and have completed medication competencies and medication education. The RN checks the robotic rolls against the electronic medication chart and signs in the pack as checked. Medication competent senior caregivers assist as second checkers when required. Medications are stored safely. There were no self-medicating residents. There is a hospital stock which is checked monthly for expiry dates.</p> <p>Medication fridge temperatures and medication room air temperatures are monitored daily and were within the acceptable range. All eye drops in the medication trolley were dated on opening.</p> <p>Ten medication charts were reviewed on the electronic medication system. All medication charts had photo identification and an allergy status documented. The effectiveness of 'as required' medications had been recorded in the electronic system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>There is a qualified cook on duty from 7 am to 5.15 pm seven days a week. There is a kitchenhand from 4 pm – 10 pm. All food services staff and care staff have completed food safety training. All meals are prepared and cooked on site with the main meal in the evening. There is a four weekly menu that has been reviewed by a dietitian June 2019. The RN completes a food and nutrition information form on each resident. Pureed meals and diabetic</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>desserts are provided. Resident likes and dislikes are known, and alternative foods are offered. There were fluids and high protein drinks available and nutritious snacks and foods available over 24 hours. The kitchen is located between the dining rooms of both homes and meals are served from the kitchen. Lip plates and specialised utensils are available as needed to promote independence at mealtimes. There were adequate staff available to assist residents with their meals as observed.</p> <p>The food control plan was verified 12 November 2019. Daily temperatures are taken and recorded for the fridges, freezer, and cooked meals, dishwasher wash and rinse cycles. There is a daily, weekly and annual cleaning schedule in place.</p> <p>Residents and relatives have the opportunity to feedback on meals directly at mealtimes, at meetings and EPOA surveys. Feedback indicates satisfaction with the meals.</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>When a resident's condition changes the RN initiates a GP or nurse practitioner consultation. The nurse practitioner visits three weekly for resident reviews and the review of level two funding for residents. The registered nurse (interviewed) stated that they notify family members about any changes in their relative's health status. Two family members (interviewed) stated their relative's needs were being met and they were kept informed on their relative's health status.</p> <p>There was one resident with cellulitis. A wound assessment, body map, measurements and wound management plan was in place. The wounds had been evaluated at the documented frequency. There had been a GP review of the wounds and there is access to wound nurse specialist at the DHB.</p> <p>Continence assessments including a urinary and bowel continence assessment, are completed on admission and reviewed monthly. Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained.</p> <p>Abbey pain assessments are completed for all residents with identified pain and on pain relief. Monitoring forms in use included behaviour monitoring, weight monitoring, food and fluid charts, re-positioning charts, toileting schedules, intentional rounding and neurological observations. Behaviour assessments and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>Millvale House employs a qualified registered diversional therapist (DT). The DT works five days a week from 10.30am to 5.30pm. These hours are the long activities shift plus she works 1pm - 5.30pm once a week. Activity relievers are caregivers who work the short activities shift (2pm - 6.30pm) four days a week and are additional to caregiver staff on duty. Caregivers also incorporate activities into their role. The DT is supported by DTs from other facilities and there are monthly 'zoom' meetings with the national educator.</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>The service provides a flexible activity programme designed to meet the needs of psychogeriatric residents. There are morning activities held in each home with integrated afternoon activities held in Tui home. There are plentiful resources available for activities such as arts and crafts, foot spas, nail care and pampering. Varying activities occur and are focused on sensory and household activities and reflect on daily activities of living such as exercises (balloon/ball), crafts, flower arranging, musical DVDs, karaoke sing-a-longs, puzzles, crosswords, walks, gardening, watering plants, barbeques, baking and folding washing. One-on-one time spent with residents includes (but not limited to) pampering, reading and garden walks.</p> <p>Festive occasions and themes are celebrated. Entertainers visit monthly. Other community visitors include cultural groups, Japanese students and church services weekly. There are weekly canine visits on Sundays. Residents (as able) and under supervision have outings to the market day on Saturdays. The service shares a wheelchair hoist van with other facilities for outings and scenic drives.</p> <p>A social profile is developed on admission and each resident has an individual activity plan and 24-hour MDT plan that includes de-escalation strategies including one on one activities. There are six-monthly MDT family meetings and resident/relative meetings. Relatives interviewed were satisfied with the activities offered.</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>Care plans reviewed identified a six-month evaluation of care and activities by the MDT including input from care staff, RN, DT, GP, NP and other allied health professionals as relevant. Family are invited to attend the MDT. There is a written evaluation that identifies if the goals of care have been met or not. Short-term care plans reviewed were either 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. Ongoing nursing evaluations occur daily/as indicated and are included within the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Millvale Waikanae has a current building warrant of fitness that expires on 12 June 2020. The facility is divided into two psychogeriatric homes of 15 beds each. There is secure access to the entrances of each psychogeriatric home.</p> <p>The operations coordinator oversees day to day operations for the facility. One owner/director at head office is responsible for building maintenance. There is a maintenance person who covers three facilities and is on site at least once a week. Minor maintenance requests and repairs recorded in the logbook are addressed and signed off. The maintenance person completes a monthly compliance schedule. External contractors are available 24/7 for essential services. Electrical equipment has been tested and tagged and clinical equipment has been serviced/calibrated annually. Hot water temperature in resident areas are monitored monthly and were within the acceptable range.</p> <p>The psychogeriatric homes have exit and entry access from several doors within the homes. Each of the two</p>

		<p>'homes' have a separate outdoor deck and landscaped garden area with safe access. There is seating and shade provided. The gardens and grounds are well maintained. There are fans available in the summer, doors that open to the courtyards and bedroom windows (with security stays) open for ventilation. There is underfloor heating in the winter adjustable from main control. Plastic bags in bins both sluice rooms has addressed previous complaints about odours. There were no odours noted on days of audit. Internal audits monitored temperature and waste and were all actioned.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for infections that meet the standard definitions. A monthly log of infections is maintained and infection events, trends and analysis are discussed with RNs prior to their RN meeting. Infection control data is collated monthly and reported at the quality improvement meetings. Meeting minutes are available to staff. Internal infection control audits 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. The service has maintained a low rate of UTIs below the industry standard (link CI 1.2.3.6.)</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 are congruent with the definitions in NZS 8134.0. Interviews with the caregivers, RN and facility manager/clinical manager confirmed their understanding of restraints and enablers. At the time of the audit, there were no residents utilising enablers and three residents assessed for using restraints (one bedrail, one waist belt and one wheelchair belt). A register is maintained by the restraint coordinator/RN. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours. The restraint coordinator, EPOA and GP are involved in the assessment and evaluation of restraint in consultation with RNs.</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.

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Benchmarking reports are generated throughout the year and an annual review of the data is completed. The service continues to collect data to support the implementation of corrective action plans. There continues to be	There are ongoing quality improvements identified through results of analysis of quality data collected. Action plans are developed where opportunities for improvement are identified. The service has a falls coordinator who attends the monthly resident event analysis meetings. Meeting minutes reviewed identified that strategies are regularly evaluated. The service has a fall reduction programme which includes initial and post-falls physiotherapy assessments, updating the falls maps of location and time of falls, GP review of medications and continuing education. Interventions for residents at risk of falls include sensor mats, wearing of hip protectors, intentional rounding, safe footwear and ensuring the environment is uncluttered. Care staff interviewed were able to describe falls prevention strategies. The falls rate has continued to decrease by 25 – 50% below the industry and DCNZ rate of 11.09 for 2019. A spike in falls to 9.68 in October 2019 (still below the industry rate) was related to a new resident and the falls reduced the next month to 5.56. Ongoing analysis of UTIs for trends identifies action plans to reduce UTIs including prompt reporting of suspected infections such as changes in behaviour and excluding medical cause. There are regular toileting regimes in place for residents, good personal hygiene for residents and good staff hand hygiene. Residents have cranberry juice and yoghurt daily. The UTI rates are well below the industry and DCNZ rates of 1.51. There were seven consecutive months from May to December 2019 with zero UTIs. The service is to be commended for maintaining

		a downward trend in falls and urinary tract infections.	low UTI rates with 28 of 30 residents who are incontinent.
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End of the report.