

Avonlea Dementia Care Limited - Avonlea Dementia Care

Introduction

This report records the results of a Certification Audit; Partial Provisional 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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Avonlea Dementia Care Limited

Premises audited: Avonlea Dementia Care

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care

Dates of audit: Start date: 7 July 2021 End date: 8 July 2021

Proposed changes to current services (if any): A partial provisional audit was completed for newly built 10 bed dementia care unit increasing the total number of beds available to 75.

Total beds occupied across all premises included in the audit on the first day of the audit: 56

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Avonlea Dementia Care provides hospital (medical, and geriatric), psychogeriatric and dementia level care for up to 65 residents. The service is divided into six separate units - a secure psychogeriatric unit, four secure dementia units and a hospital unit. Occupancy on the days of audit was 56 residents.

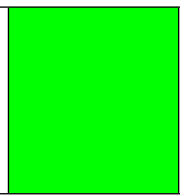
This certification audit was conducted against the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management and staff.

A partial provisional audit was also undertaken for a newly built 10 bed dementia unit which will bring the total number of beds available to 75.

An operations manager, and clinical manager manage the service on a day-to-day basis. The operations manager has been in the role two years and is supported by a clinical manager/registered nurse appointed October 2019. They are supported by a governance and clinical management team from DCNZ. Staff interviewed feel supported in their roles. The families interviewed all spoke positively about the care and support provided.

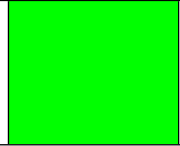
The service is commended for achieving continuous improvements around restraint minimisation and reduction in skin and wound infections.

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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Avonlea has policies and procedures that align with the requirements of the Privacy Act and Health Information Privacy Code. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is accessible to residents and families. Policies are implemented to support residents' rights. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. Care plans accommodate the choices of residents and/or their family/whānau. 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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The organisational quality and risk management plan includes goals and objectives that are regularly reviewed and discussed in facility meetings. Progress with the quality and risk management plan is monitored through the quality meeting. The operations manager and clinical manager collate and monitor all quality data and provide feedback to the staff. There is a benchmarking programme in place across the organisation. The internal audit schedule is being completed. Areas of non-compliance identified at audits have had quality improvement action plans developed and signed as completed. Relative surveys are undertaken annually. Incidents and accidents are appropriately managed. Appropriate staff are recruited and provided with a comprehensive orientation. An annual education plan has been implemented and staff have received appropriate training including dementia

specific training. There are sufficient staff on duty, including a registered nurse at all times in the hospital and the psychogeriatric home to meet the needs of the residents.

Continuum of service delivery

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

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

The service uses an electronic medication management system. All medication charts had photo identification and allergy status recorded. The general practitioner reviews medications charts at least three-monthly.

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. There are nutritional snacks available 24 hours. 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.		Some standards applicable to this service partially attained and of low risk.
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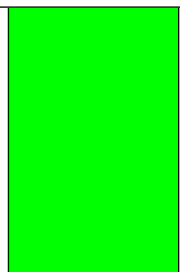
There is a current building warrant of fitness for the existing facility. The facility is divided into six separate units. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are open plan lounge and dining areas in each unit with a kitchenette. Furniture is appropriately placed to the setting and arranged in a way to allow residents to mobilise safely. There is a designated laundry, which includes storage of cleaning and laundry chemicals. Chemicals and cleaning trolleys are stored securely when not in use. The service has implemented policies and procedures for civil defence and other emergencies. Communal living areas and resident rooms are appropriately heated and ventilated. 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.		All standards applicable to this service fully attained with some standards exceeded.
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Restraint policies and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. The service had two residents using restraints and no residents using enablers. A register is maintained by the restraint coordinator/registered nurse. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. Information is obtained through surveillance to determine infection control activities.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	47	0	2	0	0	0
Criteria	2	96	0	3	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	There is a code of rights policy and procedures in place. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is incorporated into care. Discussions with three registered nurses (RN), six caregivers, two home assistants, two diversional therapists (DT) and one cook identify their familiarity with the code of rights. Discussion with five family members (three dementia care, one hospital and one psychogeriatric residents) confirm the service functions in a way that complies with the code of rights. Observation during the audit confirmed this is occurring in practice. The Code training is included in the staff orientation and in the ongoing education planner.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed	FA	There are established informed consent policies/procedures and advanced directives. General consent is obtained for sharing of health-related information, photograph for identification and social display and consent for outings. All eight files reviewed (two hospital level of care, two psychogeriatric and four dementia) included completed consents. Permission granted is signed as part of the admission agreement. There was documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents' advance directive where applicable was available on file. All files reviewed of residents in the secure units (four dementia, two psychogeriatric) had copies of the activated EPOA on file. Interviews with five family members (one hospital, one psychogeriatric and three

consent.		dementia level of care) state they have input in care and choices are offered on a daily basis. Long-term care plans and 24-hour multidisciplinary care plans demonstrate resident choice as appropriate.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The right to access advocacy services is identified for residents/families and brochures are available at the front entrance. The information identifies whom to contact to access advocacy services. Information provided to families prior to entry to the service provides them and family/whānau with advocacy information. Staff are aware of the right for advocacy and how to access and provide advocacy information to relatives/residents if needed. Advocacy and Code of Rights training was delivered by an advocacy representative in March 2021.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The service has open visiting hours. Family are actively encouraged to visit as observed on the day of audit. Relatives interviewed stated they could visit at any time and staff made them feel welcome when they visited. Community entertainers, church groups and volunteers visit the "homes".
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 concerns/complaint forms and information available at the entrance and in each home. Information about the complaints process is provided on admission. Staff interviewed could describe the process around reporting concerns/complaints. The operations manager is responsible for the management of complaints in consultation with the clinical manager and national clinical manager for care complaints. An on-line complaint's register includes date of complaint, acknowledgment date, investigation, outcome and complainant response/resolution. There were seven internal and one Health & Disability complaint in 2019 and three internal complaints for 2020 and two internal complaints for 2021 year to date. Verbal complaints had been documented in the register. All concerns/complaints had been acknowledged and investigated within the HDC required timeframes. Letters of investigation and outcomes offer advocacy. A complaint to the health and disability commission from December 2019 was closed in January 2021. Recommendations in relation to the complaint have been implemented.

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code of Rights posters are displayed in each “home” within the facility. The information pack for new residents/families on entry includes information about the Code, complaints procedure and services provided including the safe environment for dementia and psychogeriatric residents. Resident and families right to access advocacy services is identified and advocacy service leaflets are also available at the front entrance. On entry to the service, the operations manager or clinical manager discusses the information pack with the resident (as appropriate) and their family/whanau/enduring power of attorney (EPOA). Discussions with the caregivers and registered nurses identify they are aware of the right for advocacy and how to access and provide advocacy information to residents/relatives if needed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and ongoing assessment includes gaining information of resident’s beliefs and values in consultation with the resident (as appropriate) and relative/EPOA. Interventions to support these are identified in the care plans and evaluated to ensure the residents needs are being met. Care staff interviewed describe how a resident’s privacy and dignity was maintained. Staff sign a confidentiality clause contained within the employment agreement on employment.</p> <p>The service's philosophy focuses on residents' right to respect, privacy and safety and have adopted the “best friends” approach to resident care. There is a policy that covers abuse and neglect and staff have completed abuse and neglect training with Dementia New Zealand (September 2019). During the visit, staff demonstrated knocking on doors prior to entering resident private areas. Interviews with care staff confirmed a good understanding of abuse and neglect and their associated responsibilities. Interviews with family members identified that caregivers are always respectful and caring.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are policies and procedures for the provision of culturally safe care for Māori residents. On the day of the audit there were two residents who identified as Maori. Specific cultural needs are documented in the care plan and activity plan as sighted in the two Maori resident files reviewed. Family/whānau involvement is encouraged in assessment and care planning. Links to Iwi and local Marae are identified in the care plans. There is a Māori Health plan and current guidelines for the provision of culturally safe care for Māori residents. Bi-cultural awareness training is included in the annual in-service education programme. The education coordinator provides assistance and guidance for Maori residents as needed.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The staff focus on the residents' right to be accepted as an individual and being given the opportunity to enhance the values and beliefs in their lives. Each resident has an individualised care plan which reflects their values including cultural and spiritual beliefs. There is evidence the family/whānau is involved in the development of the care plan. Family members interviewed state the resident's individual culture, beliefs and values are met. Regular church services are held. Staff receive training on cultural diversity.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the staff files sampled. Staff comply with confidentiality and the code of conduct. The registered nurses and allied health professionals' practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the operations manager, the clinical manager, registered nurses and care staff confirmed an awareness of professional boundaries. Discussions with the operations manager and a review of complaints identified no complaints of this nature.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>An implemented quality improvement programme includes performance monitoring. A quality monitoring programme is implemented and this monitor contractual and standards compliance and the quality-of-service delivery. The service monitors its performance through resident/relatives' meetings, surveys, quality meetings, health and safety meetings, RN meetings, restraint approval group and infection control meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management.</p> <p>The education programme includes the required mandatory education topics including clinical in-services that meet hospital and medical level of services. Education is provided around dementia, delirium and depression, de-escalation and disengagement. Staff are supported by a workplace wellbeing programme and a counsellor visits the site weekly and is available for staff and families if required. Staff interviewed stated they were well supported by the governance and management team.</p> <p>General practitioner visits for staff are partially subsidised by the company.</p> <p>Monthly operations and clinical bulletins are published for staff and include information such as quality data results (accidents/incidents), infection control surveillance, and education opportunities. There is staff debriefing following incidents of challenging behaviours with good management and team support.</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. An introduction booklet provides information on the secure dementia homes and psychogeriatric home. A quarterly newsletter “our home” is published and distributed to family (or emailed) and available at the main entrance. There are six-monthly multidisciplinary team (MDT) meetings with the resident (as appropriate) and family/whanau/EPOA. Monthly family support meetings are held. Families are informed on service updates including the outcomes of surveys.</p> <p>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. Twelve incident/accident forms were reviewed for June and July 2021 and all forms evidenced family had been informed. Relatives interviewed, confirmed they are notified of any changes in their family member’s health status and spoke positively around all aspects of communication. Review of resident records confirmed communication is occurring.</p> <p>An interpreter service is available if needed.</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 NZ Limited (DCNZ) is the parent company under which Avonlea operates. Avonlea provides hospital, dementia and psychogeriatric level of care for up to 65 residents. On the day of audit there were 56 residents. There were eight hospital level residents, 37 dementia care and 11 psychogeriatric level of care. On the day of audit there were 45 residents under the ARRC and 11 residents under the specialist hospitals contract (ARHSS).</p> <p>DCNZ has an overarching two yearly business plan that is developed in consultation with managers and reviewed regularly. The overall business plan includes the vision, values and philosophy of the company including providing a right based, social model of care where freedom, participation and living in a way that reflects each resident’s life is of paramount importance. There is a resident focus on individualised care in small homes and specialist dementia understanding. There are six smaller home environments for residents at Avonlea; Awhi Whanau home-an 8-bed dementia, Hoa Pumau home-16 bed dementia, Ofa - 10 bed dementia, Rudo - 10 bed rest home, Aroha – 11 bed psychogeriatric home and Mahal – 10 bed hospital.</p> <p>DCNZ has a corporate structure that includes two managing owner/directors and a governance team of managers including an operations management leader, clinical advisor, national clinical manager, quality systems manager and national education coordinator. The national clinical manager and education coordinator were present during the audit. The site operations manager (non-clinical) has been in the role two years and reports to the operations management leader at head office. A clinical manager was appointed in October 2019. Prior to the appointment, she had three and a half years’ experience as an RN at Avonlea. The MOH was notified of the clinical managers appointment.</p> <p>The organisation holds an annual training day for all operations and clinical managers. The two-day</p>

		<p>conference for managers was last held in April 2021 for clinical managers, and June 2021 for operations manager. This is attended by representatives of all DCNZ facilities. The clinical manager completed a self-directed learning package specific to the role and has attended DCNZ clinical manager conference. Both managers have been supported by the organisational team who visit the site regularly.</p> <p>Partial Provisional: The addition of ten new rooms and the refurbishment of existing homes is documented under environment in the current business plan. There is a process for the transition. Avonlea ownership and management structure will continue as is. The managers are well supported by the director and management team, with at least weekly communication via on site visits, email and phone calls. The manager reports to the directors on matters relating to occupancy and finances.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence of the operations manager, the clinical manager assumes the role with support from the DCNZ management team. In the absence of the clinical manager a senior RN will cover the role with support from the DCNZ clinical management support team.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Avonlea has a current quality risk management plan, health and safety plan and infection control plan which are all reviewed by the quality team six-monthly. Clinical goals such as falls reduction, pressure injury prevention and management of acute and chronic pain is included in the 2020 quality plan.</p> <p>Progress with the quality and risk management programme is monitored through the six-monthly organisation wide quality meetings. A representative from head office usually attends the monthly quality on site meetings. The operations manager and clinical manager log and monitor all quality data and report any corrective actions required to achieve compliance where relevant. Quality data reported includes falls, behaviour incidents, bruises, skin tears, infections, medication errors and restraint use. Data is collated for benchmarking and results reported back to the facility for quality improvement plans if required. The operations manager produces a monthly bulletin which includes current risks, audit outcomes, family feedback and general overview from facility meetings. The clinical manager produces a monthly clinical bulletin which includes resident related concerns, clinical data, corrective actions clinical audit outcome and clinical benchmarking results. In addition, there is a monthly resident event analysis management meeting which includes the RN/falls coordinator. There are monthly quality improvement, health and safety meetings, monthly infection</p>

		<p>committee meetings, home manager meetings, cooks' meetings, DT meetings and RN meetings. Meeting minutes and monthly bulletins are available for all staff in the staff room. Discussions with staff confirmed their involvement in the quality programme.</p> <p>The service has policies and procedures to support service delivery for all levels of care and includes policies related to medical services. The policy and document development and review group at head office review policies in consultation with relevant staff and distribute to the facilities. Staff are informed of any new/reviewed policies.</p> <p>The internal audit schedule for 2020 has been completed and 2021 is being completed as scheduled. Internal audits cover all non-clinical, clinical and environmental areas. The audits are delegated to the relevant person or coordinator. Areas of non-compliance identified at audits (less than 100%) have corrective action plans developed and signed off as sighted on the electronic system. Re-audits are completed as required. Audit results are discussed at meetings and documented in minutes and the monthly bulletins.</p> <p>The service receives feedback from surveys including a family restraint survey and annual EPOA satisfaction. There were 22 responses from the EPOA survey with an overall satisfaction rate of 95%. Relatives interviewed were very happy with the care provided stating staff were very approachable, welcoming, compassionate, caring genuine and respectful to residents and relatives.</p> <p>The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. A diversional therapist has been in the role of health and safety representative for two years and has completed on-line workplace health and safety and hazard management training. Two health and safety representatives (interviewed) both attend the monthly health and safety committee meeting. Staff have the opportunity to raise any concerns for discussion and preventive/corrective actions are fed back to staff. Hazards are reported and reviewed. The hazard register is reviewed three-monthly last in June 2021. The health and safety representative confirmed that contractors had cordoned off the new dementia home safely during construction. All contractors complete a site health and safety induction.</p> <p>Falls prevention strategies are in place that includes assessment of risk, medication review, sensor mats, physiotherapist assessments, exercises/physical activities, falls coordinator input, training for staff on prevention of falls and environmental hazard awareness. The physiotherapist provides frequent safe manual handling/hoist training competencies. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</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, RN assessment and any follow-up action</p>

<p>untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>commenced.</p> <p>Twelve incident/accident forms reviewed on the electronic system were fully completed and followed-up appropriately by the RN. Minutes of the monthly quality meeting, health & safety meetings, resident event analysis (REA) meetings and RN/clinical meetings reflected a discussion of incidents/accidents and actions taken. Neurological observations are completed (as far as practical) for un-witnessed falls or head injury (actual or potential).</p> <p>Discussions with the operations manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been nine Section 31 notifications completed since 2019. Notifications included four for RN coverage, one for visitor trespass, three for respiratory outbreaks and one for police involvement in an external incident.</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>Nine staff files were reviewed (one clinical manager, one operations manager, two registered nurses, two caregivers, one diversional therapist, one home assistant and one cook). Job descriptions, reference checks and employment contracts were evident in all files reviewed. Performance appraisals were up to date. A copy of practising certificates was sighted for all registered nurses and allied/medical staff.</p> <p>The service has in place a comprehensive orientation programme that provides new staff with role specific information for safe work practice. There are self-directed learning packages for infection control, health and safety and restraint.</p> <p>Care staff interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service. All nine files reviewed showed evidence of orientation to roles with competency packages completed. Competency packages are completed relevant to the role including medication administration, safe manual handling, restraint minimisation and safe practice, safe food handling, infection control, advocacy and abuse and neglect.</p> <p>The annual training programme for 2020 has been completed and the 2021 education schedule is being implemented with monthly education sessions that covers all required topics and includes clinical in-service. Staff can access on-site education sessions by zoom. External speakers/presenters are included in the training schedule such as pharmacist, physiotherapist, hospice nurses, fire safety and HDC advocate. Registered nurses have the opportunity to attend DHB study days.</p> <p>The national education coordinator is a registered psychiatric nurse and careerforce assessor. He provides regular staff training on the 'best friends' model of care, challenging behaviours, and de-escalation and disengagement. All staff are required to complete Best Friends sessions 1 and 2. To date 41 of the 63 staff have completed both sessions.</p> <p>The education coordinator /careerforce assessor supports caregivers to complete the required aged care</p>

		<p>education and dementia unit standards for those staff working in the dementia and psychogeriatric homes. There are 33 caregivers who work at Avonlea. Thirty-two staff have completed dementia unit standards, one is in the process of completing the dementia unit standards. Thirteen care staff have level three or four Careerforce qualifications.</p> <p>There are ten registered nurses, including the clinical manager. Eight registered nurses and the clinical manager have completed interRAI training.</p> <p>Partial Provisional: The director advised that once approval is received to occupy, the new home will initially be used to relocate residents and staff from other homes while refurbishments occur. Further care staff will be recruited as resident numbers increase and as required. Existing recruitment practices will be implemented in the procurement of new staff.</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>The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. The operations manager and the clinical manager work fulltime Monday to Friday. The operations manager is on-call for non-clinical concerns and the clinical manager provides 24 hours on call for clinical matters.</p> <p>There are two RNs on duty each shift over 24 hours. The RNs are based in the hospital and psychogeriatric homes and also provide RN input and oversight of the four dementia homes. The clinical manager is rostered one to two shifts per week in the psychogeriatric home.</p> <p>Sufficient staff are rostered on to manage the care requirements of the residents. All caregivers are able to rotate through all the homes if required to provide cover however care staff and home assistants are allocated to a home to provide consistency of care for their residents that they know so well. Agency staff are not used. Care staff interviewed stated there are enough staff on duty to meet the needs of the residents. Relatives interviewed stated there were sufficient staff on duty when they visited.</p> <p>Support staff is as follows:</p> <p>Awahi Whanau home (8 dementia beds and 7 residents). Morning shift: one caregiver 7am-3pm. Afternoon shift: one caregiver from 3pm-12 midnight. Night shift: one caregiver (midnight to 8 am).</p> <p>There are diversional therapy hours from 1:30pm to 4.30pm.</p> <p>There is a home assistant on duty from 8am-3pm and from 4.30-8pm.</p> <p>Hoa Pumau home (16 dementia beds and 12 residents): Morning shift: two caregivers from 7am-3pm. Afternoon shift: two caregivers - one from 3pm-12 midnight and one from 4.30- 8pm. Night shift: one home</p>

		<p>assistant (midnight to 6:45am). Care is provided by the caregiver or RN on night shift in the rest home/hospital.</p> <p>There are diversional therapy hours from 1.30-4.30pm.</p> <p>Ofa home (10 dementia beds 9 residents);Morning shift: two caregivers one from 7am-3pm and one from 7 to 12:30pm, Afternoon shift: two caregivers - one from 3pm-12 midnight and one from 4:30 -8pm. Night shift: one caregiver (midnight to 6:45am). The night caregiver is shared between Ofa and Rudo with assistance from one of the two RNs on night shift.</p> <p>There are diversional therapy hours from 1.30-4.30pm.</p> <p>Rudo home (10 dementia beds and 9 residents):Morning shift: one caregiver from 7am-3pm; Afternoon shift: one caregiver from 3pm-12 midnight and one from 4:30 to 8pm</p> <p>Night shift: one caregiver (midnight to 8 am). Assistant if required is provided by the caregiver or RN on night shift in the hospital.</p> <p>There are diversional therapy hours from 1.30-4.30 pm.</p> <p>There is a home assistant on duty from 8am-1:30pm and from 4.30-8 pm</p> <p>Aroha home (11 psychogeriatric beds and 11 residents): Morning shift: one caregiver from 7am-3pm, Afternoon shift: one caregiver from 3pm-11pm; Night shift: RN on duty. Assistance if required is provided by the caregiver or RN on night shift in neighbouring homes.</p> <p>There are diversional therapy hours from 11am-to 1pm and 1pm to 4.30pm.</p> <p>There is a home assistant on duty from 8am-1:30pm and from 4.30-8pm</p> <p>Mahal home (10 hospital beds and 8 residents); Morning shift: one caregiver from 7am-3pm, Afternoon shift: two caregivers - one from 3pm-11pm</p> <p>Night shift: RN on duty. Assistance if required is provided by the caregiver from neighbouring homes.</p> <p>There are diversional therapy hours from 10am to 1pm</p> <p>There is a home assistant on duty from 8am-11:30pm and from 4.30-8pm</p> <p>The role of the home assistant is to provide non-clinical support including laundry and cleaning duties. Home assistants have completed food safety, chemical safety, health and safety and infection control training as well as other compulsory education.</p>
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<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked in a secure area. Resident records are kept up to date and reflect residents' current overall health and care status. Active archives are appropriately stored and are accessible as required.</p> <p>Entries are legible, dated and signed by the relevant staff member including designation. Resident files are integrated.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents are assessed prior to entry by the needs assessment coordinators and where required by the psychogeriatric team. The operations and clinical manager liaise closely with the assessing teams to ensure Avonlea can meet the prospective resident's needs. Family members interviewed stated that they received sufficient information on the services provided and are appreciative of the staff support during the admission process. There is a welcome pack that includes specific information around the secure homes and behaviours that may be displayed.</p> <p>Admission agreements reviewed in files align with the ARRC and aged residential hospital specialised services (ARHSS) contracts. Exclusions from the service are included in the admission agreement and the information provided at entry includes examples of how services can be accessed that were not included in the agreement. Admission agreements had been signed in a timely manner.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs using the DHB yellow envelope system . Relatives are notified if transfers occur.</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>There are policies and procedures in place that aligns with recognised standards and guidelines for safe medicine management practice. Medications are stored safely in each of the homes. Registered nurses administer medications in the hospital level homes and medication competent caregivers administer medications in the dementia care homes. All staff who administer medications have completed annual medication competencies and education. Registered nurses complete syringe driver competencies. The service is supported by Nurse Maude for end-of-life care. Regular medications are delivered fortnightly in robotic rolls and as required medication are in blister packs. All medications are checked on delivery against the electronic medication chart and entered as “pack checked in” by a RN. There is an impress stock of medications for hospital level residents only, which is checked monthly for stock levels and expiry dates. Standing orders are in place that meet the standing order regulation and are reviewed by the GP annually. Restricted medications are stored in the hospital unit. There were no residents self-medicating. The two-medication fridges and medication room air temperatures are being monitored and within acceptable limits.</p> <p>Sixteen electronic medicine charts (four hospital, four psychogeriatric and eight dementia care) had photo identification, allergies documented and evidence of a three-monthly GP review. As required medications were appropriately prescribed and documented indications for use. The effectiveness of ‘as required’ medications were recorded in the electronic medication system and progress notes.</p> <p>Partial Provisional: There is no medication cupboard in the new unit. The medication trolley and medications will be accessed from the adjoining psychogeriatric home.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of</p>	<p>FA</p>	<p>All meals at Avonlea are prepared and cooked on-site in a fully equipped kitchen which is located off the psychogeriatric unit. There is a four-weekly rotating summer and winter DCNZ menu which has been reviewed and approved by a dietitian last June 2019. There is a cook on duty from 6.30am to 5.30pm. The cook is supported by a kitchenhand commencing at 4.30pm to assist with the evening meal (main meal of the day). All staff involved in preparing, cooking and serving of meals have completed food safety training. The cook receives a dietary requirement form for each resident which is updated at least six-monthly. Dietary needs are known with individual likes and dislikes accommodated. The cook is notified of any changes, special diets or weight loss. Soft/pureed, gluten free and diary free diets are provided. Containers of nutritional snacks and</p>

<p>service delivery.</p>		<p>finger foods are delivered regularly to the home kitchenettes. Dietitian recommendations are followed as instructed.</p> <p>A food control plan is in place expiring 16 April 2022. Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded on each meal. All food is stored correctly, and date labelled. Chemicals are stored safely. There is a monthly check on chemical effectiveness for the dishwasher. Staff were observed to be wearing appropriate personal protective clothing.</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>Partial Provisional: The new 10-bed unit has a fully functioning kitchenette for the serving of meals and preparation of snacks. The hot water urn is behind a locked cupboard door. Meals will be delivered in hot boxes from the main kitchen.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to residents is recorded should this occur and communicated to the resident and family (as appropriate). The clinical manager reported that the referring agency would be advised when a resident is declined access to the service being unable to meet the level of assessed care or if there were no bed available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The information gathered at admission is used to develop care needs and supports to provide best care for the residents. A range of paper-based risk assessments are completed on admission and completed as part of the interRAI assessments. InterRAI assessments had been completed for all residents and completed six-monthly or earlier for a change in health status. The outcomes of interRAI assessments were reflected in the long-term care plans reviewed. The diversional therapists and other activities staff complete a social assessment, activity care plan and a 24-hour activity multidisciplinary plan in consultation with the resident/family.</p> <p>Residents with identified behaviours that challenge included a behaviour assessment and behaviour management plans in place.</p> <p>The two psychogeriatric residents' files reviewed included an individual assessment that included identifying diversional, motivation, and recreational requirements.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The outcomes of interRAI assessments re linked to the long-term care plan. Care plans reviewed included supports and interventions to meet the resident goals including daily activities of living and medical needs. Short-term care plans are used for short-term needs, reviewed regularly and if unresolved transferred to the long-term care as an ongoing problem. The relatives sign the long-term care plan to evidence involvement in the care planning process. Files reviewed demonstrated allied health input into the resident's care and well-being. Family members interviewed confirmed they are involved in the care planning process.</p> <p>Two files reviewed of residents in the psychogeriatric (PG) unit and four 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. Behaviours that challenge have been identified through the assessment process. Twenty-four-hour multidisciplinary care plans describe the resident's usual signs of wellness, changes and triggers, interventions and de-escalation techniques (including activities), for the management of challenging behaviours.</p> <p>Care plans were integrated. Physiotherapist assessment, management plans, dietitian and allied health involvement were reflected in the long-term care plans.</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 specialist consultation. Caregivers follow the care plan and report progress against the care plan each shift at handover as observed. If external nursing or allied health advice is required, the RNs will initiate a referral (for example to the Nurse Maude service, mental health service or needs assessment team.). 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.</p> <p>Staff have access to sufficient medical and dressing supplies. There were two wounds currently being managed by the service (one superficial graze and one haematoma). Each wound has an assessment, plan and evaluations recorded, which show progression or deterioration towards wound healing. There were no chronic wounds. There were no pressure injuries on the day of 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>Monitoring charts were sighted for food/fluid, output charts, AWOL monitoring weights and observations, pain, turning charts and restraint. Behaviour charts 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 consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a team of seven activity coordinators, four of whom are diversional therapists (DT). They provide an activities programme for part of each day, seven days a week, in each of the units. The programmes are flexible and outdoor activities weather dependant. The programme is implemented from 11am to 4.30pm in the psychogeriatric home. One DT is based in the hospital home each morning and care staff provided one on one time in the afternoons. There is an activity coordinator/DT based in each of the four dementia homes from 1.30 - 4.30 pm. Care staff provided one on one time and small group activities at other times. There are resources available to staff for activities.</p> <p>The programme for the psychogeriatric residents and dementia level of care 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, feeding birds, garden walks, games, music and movies. The programmes provide activities of normal life for all residents such as cleaning, flower arranging, folding washing, sewing/kitting and outdoor activities. There are regular singalongs, reminiscing and aromatherapy. There is a memory room that is accessible under supervision for all residents. 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. The men's club include men from all the levels of care who get together to chat and participate in men's interests such as gardening, vintage cars etc. The ladies group meet for chats, pampering activities and knitting.</p> <p>Entertainment is scheduled regularly in each unit. Canine friends visit fortnightly. There are integrated church services. There is weekly van outing for residents. The activities staff have current first aid certificates. The service has a van with a wheelchair space and at least two staff attend all van outings.</p> <p>Activity assessments, activity plan, 24-hour MDT care plan, progress notes and attendance charts are maintained. 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. The activity plan is evaluated six-monthly at the MDT meeting with the RN, resident/relative as appropriate.</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 and small group activities were observed to be occurring in the lounges of each home during the audit. Relatives interviewed were satisfied with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>Files reviewed demonstrated that long-term care plans had 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. The multidisciplinary team meetings for care plan evaluations include the RN, care staff,</p>

evaluated in a comprehensive and timely manner.		resident/relative, physio, GP and other allied health professionals involved in the care of the resident. Where progress is different from expected, the service has updated changes in the long-term care plans reviewed.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists, dietitian and other allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed, and the resident was reassessed from dementia care to psychogeriatric and from respite care to dementia level of care.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies and procedures in place for waste management. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored securely. The laundry/slucie room in the hospital wing is locked when not in use. Product use information and safety data sheets are available. Protective equipment including gloves, aprons, and goggles are available and were observed to be worn by staff carrying out their duties on the day of audit. Relevant staff interviewed had completed chemical safety training. Partial Provisional: Buckets with lids will be used to transport linen to the sluice room, central to the four homes in that area if required.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their	PA Low	Avonlea is divided into six units, known as homes. There are four dementia units, one psychogeriatric unit and one hospital unit. A newly built 10-bed dementia care unit was assessed on the day of audit. The facility displays a current building warrant of fitness, which expires on 1 June 2022, however there is no code of compliance in place for the new 10-bed unit. The managing director and operations manager share the responsibility for maintenance and repairs. There is a maintenance person and gardener who works between the two local facilities spending 1.5 days/week at Avonlea. There are maintenance books in each home that are checked daily for requests. There is a scheduled maintenance plan in place that includes call bell checks, testing and tagging of equipment, calibration of clinical equipment and monthly security checks of all fences

<p>purpose.</p>		<p>and gates. Hot water temperature checks are conducted randomly weekly in all homes. Re-checks and corrective actions are documented for hot water temperatures above 45 degrees Celsius. Essential contractors are available 24 hours.</p> <p>Residents were observed safely mobilising throughout their home environment. There is easy access to the outdoors from each home. The interior courtyards and gardens for each home are well maintained with safe paving, outdoor shaded seating, lawn and gardens. The residents can access secure outdoor areas with walking pathways. Interviews with the registered nurses and the caregivers confirmed that there was adequate equipment to carry out the cares according to the residents' care plans. There are refurbishment plans in place for the homes and a new commercial kitchen.</p> <p>Partial Provisional: There is sufficient space for residents to mobilise safely. There are several exit/entry doors to the external walking pathway and gardens, raised gardens and seating. A veranda provides shade.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mix of resident rooms with ensembles, shared ensembles and communal facilities are provided. All have hand basins. There is a large communal bathroom in the hospital and psychogeriatric homes that can accommodate a shower trolley if required. There are sufficient communal toilets adjacent to the lounge and dining areas. fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets and showers are identifiable and include vacant/engaged signs.</p> <p>Partial Provisional: Eight resident rooms have ensembles and there are two standard rooms with hand basins and within close location to the large communal bathroom.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>The resident rooms including those in the new 10-bed unit, are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. Bedrooms are personalised as viewed on the day of audit.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large communal lounges and dining areas in each unit. There are also smaller seating areas for residents and families to access. Communal areas in each unit are used for activities, recreation and dining activities. There is a memory room accessible to all residents under supervision. All six dining rooms are spacious and located directly off the kitchen/servery area. All areas are easily accessible for residents. Residents were seen to be moving freely both with and without assistance throughout the audit.</p> <p>Partial Provisional: There is an open plan lounge/dining area with seating placed appropriately for small group dining and activities. There is an additional small lounge/family room with doors that open onto the garden area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area with defined clean/dirty areas and entry/exit doors which is based in the hospital level home. All laundry and personal clothing is laundered by a home assistant. Cleaners are employed seven days a week from 9am-12.30pm. Cleaning trolleys are locked away when not in use. Cleaners carry chemicals with them in buckets when working in the secure units. The effectiveness of laundry and cleaning processes are monitored by the chemical provider. Staff attend safe chemical handling and infection prevention and control education. There is appropriate protective clothing available.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	PA Low	<p>The service has a fire and emergency procedures manual. New Zealand Fire Service has approved the evacuation scheme for Avonlea in November 1994. Six-monthly fire drills are conducted. There is a trained person with a first aid certificate on each shift. Fire safety training has been provided. There is a call bell system in place. A civil defence kit is stocked and checked monthly. Water is stored, sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. There are emergency management plans in place to ensure health, civil defence and other emergencies are included.</p> <p>There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergency management and self-directed learning packages are completed as part of orientation and ongoing education plan. All RNs and DTs have a current first aid certificates providing staff on duty 24 hours with a first aid certificate. The facility has an approved fire evacuation plan for the existing building; however the fire service has not yet approved the fire evacuation scheme for the new 10 bed dementia care home. Fire drills occur six-monthly. In the event of a power failure, emergency lighting, battery backup for call bells and alternative cooking is available. There are sufficient food supplies for at least three days and an emergency menu is available. The service is on a priority hire list for a generator as required. There are civil defence supplies (checked monthly) that are readily accessible and include torches, batteries and radios. Three</p>

		<p>external 50,000 litre tanks of water provide at least three litres water per person for three days. Call bells are evident in resident's rooms, lounge areas and toilets/bathrooms. The facility is secured at night with external sensor lighting in place. All external doors are alarmed. Entry and exit to the dementia and psychogeriatric homes are secure.</p> <p>Partial Provisional:</p> <p>An application has been lodged with the New Zealand Fire Service for a new fire evacuation scheme. A new electronic call system has been installed in the new area and is operational, including a link for emergency calls to the adjoining home. The new home has been included in the existing emergency management plan.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All communal and resident bedrooms have external windows with plenty of natural sunlight. There are heat pumps in communal areas/corridors and gas fires in lounges in some homes. Ceiling heating is centrally controlled. There are individual electric heaters in resident rooms that can be individually controlled. The general living areas and resident rooms were appropriately heated and ventilated. Family interviewed stated the environment is comfortable.</p> <p>Partial Provisional: There is underfloor heating and a heat pump in the lounge/dining area and individual electric heaters in the resident rooms.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Avonlea has an established infection control (IC) programme that is being implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. An experienced RN is the designated infection control nurse with support from the infection control committee and national clinical manager. Meeting minutes are available for staff. The infection control nurse attends six-monthly organisational meetings via zoom to review the infection control programme.</p> <p>Visitors are asked not to visit if unwell. There is signage in place and Covid screening continues. Staff and residents have been offered influenza and Covid vaccines. There are adequate hand sanitisers placed throughout the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate</p>	FA	<p>There are adequate resources to implement the infection control programme at Avonlea. The infection control (IC) nurse has maintained their practice by completing WHO (World Health Organization) on-line education, DHB health-learn infection control course and regional South Island infection control on-line updates. The infection control team is representative of the facility. External resources and support are available when</p>

human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		required from within the organization, DHB, Nurse Maude, GP, laboratory and public health.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The infection control policies and procedures are reviewed by relevant personnel at head office in consultation with clinical managers and infection control nurses. The RN have access to policies on the intranet and are notified of any new/reviewed policies.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control. All staff complete infection control training as part of the orientation process which includes handwashing competencies. All staff attend annual infection control education and complete an annual competency. There were daily meetings during Covid restrictions keeping staff updated on alert levels and outbreak management procedures. The DHB visited the site to assess and advise on Covid preparedness.</p> <p>Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs. Families were kept updated throughout the Covid restrictions by email/phone/zoom meetings and facebook page.</p>
Standard 3.5: Surveillance	FA	The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control

<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>		<p>activities, resources, and education needs within the facility. Goals identified for improvement are reduction of wound and skin infections by 50% and reduction of urinary tract infections (UTI) in the dementia care homes by 10%. The service has achieved its goal for the reduction of skin and wound infections.</p> <p>Individual infection report forms and short-term care plans are completed for all resident infections. Infections are collated in a monthly register and a monthly report is completed by the infection control nurse. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality/infection control and staff meetings. Internal infection control audits also assist the service in evaluating infection control needs. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities.</p> <p>There have been three respiratory outbreaks of rhinovirus in July 2020, April 2020 and November 2020. All were contained within the dementia care homes. Case logs and notification emails to public health were sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes restraint procedures. The restraint coordinator is a registered nurse. Interviews with caregivers and nursing staff confirm their understanding of restraints and enablers. There were two residents with restraint and no residents using enablers on the day of audit. Staff complete restraint competencies and attend education and training in restraint minimisation and safe practice. The service has been successful in continuing to reduce the use of restraint</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and</p>	<p>FA</p>	<p>Responsibilities and accountabilities for restraint are outlined in the restraint policy and include roles and responsibilities for the restraint coordinator (RN) and approval group. A restraint approval group meets six-monthly. The group includes the restraint coordinator, clinical manager, operations manager, Diversional Therapist, company educator and a family representative.</p>

others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments are undertaken by the restraint coordinator/RN in partnership with the resident and their family. Restraint assessments are based on information in the care plan, family, staff and GP consultation and during observations. Two files sampled for residents with restraint demonstrated that the restraint assessment tool is completed for residents requiring an approved restraint for safety. There is provision for emergency restraint if required for safety of the residents, other residents/staff.</p> <p>Ongoing consultation with the family and staff is evident through multidisciplinary meetings and facility meetings. Two restraint files reviewed included completed assessments that considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the family, restraint coordinator and GP. Internal audits are completed three-monthly, ensuring all restraint processes are completed as per the restraint policy and procedures. The restraint coordinator reports that each episode of restraint is monitored at predetermined intervals, depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form (sighted). All restraints are only used intermittently with each of the two records sampled having frequent days when restraint is not used at all.</p> <p>A restraint register is in place providing an auditable record of restraint use. This has been completed for all residents requiring restraints.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur monthly in the registered nurses meeting and six-monthly as part of the multi-disciplinary review for the resident on restraint. Families are included as part of this review. A review of two files of residents using restraints identified that evaluations were up to date.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p>	CI	<p>At the monthly facility quality meetings, RN meetings, staff meetings and six-monthly restraint meetings, restraints are discussed and reviewed. Any incidents of emergency physical restraint (which are infrequent and documented and investigated through the incident reporting system) are also reviewed at these meetings.</p>

Services demonstrate the monitoring and quality review of their use of restraint.		Meeting minutes include a review of the restraint and challenging behaviour education and training programme for staff. Staff receive orientation in restraint use on employment. There is internal benchmarking.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The existing facility has a current building warrant of fitness. The new 10 bed unit is yet to have a code of compliance.	The new 10-bed unit does not have a code of compliance.	Ensure the new 10-bed unit has a code of compliance. Prior to occupancy days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security	PA Low	All staff attend annual in-services on fire safety and emergency management. Trial evacuations are held six-monthly	A fire drill involving the new home has not yet been held	Ensure a fire drill is held within three months of occupancy

situations. This shall include fire safety and emergency procedures.				Prior to occupancy days
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	PA Low	<p>Building plans (including fire walls and fire separations) were approved in building consents prior to construction of the 10-bed dementia home. The facility is waiting for the code of compliance to be issued. One owner/director (interviewed) is applying for a fire evacuation scheme. The required information has been submitted to the fire service.</p>	<p>The updated fire evacuation procedure has been set to the Fire Service and the provider is awaiting a response.</p>	<p>Ensure the Fire Service approves the updated fire evacuation procedure for the new build.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. All infections are individually logged monthly. The data has been monitored and evaluated monthly and annually and is benchmarked internally.</p>	<p>In February 2020, Avonlea developed a goal of reducing the incidence of skin and wound infections by 50%. The service implemented the following strategies around reducing the incidents of skin and wound infections that included: clinical manager training at advanced nursing practice, education on the importance of reporting early signs and symptoms of skin and wound infections, wound care training for all staff and infection control education. There were no wound infections on the day of audit and only three wounds across the service levels. The goal was reviewed six monthly and achieved in July 2021 with a current rate of .82 per 1000 bed days compared with 1.7 per 1000 bed days in 2019 and 1.2 per 1000 bed days in 2020.</p>

		Avonlea has been successful in achieving its goal to reduce skin and wound infections by 50% since 2019.	
<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <p>(a) The extent of restraint use and any trends;</p> <p>(b) The organisation's progress in reducing restraint;</p> <p>(c) Adverse outcomes;</p> <p>(d) Service provider compliance with policies and procedures;</p> <p>(e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice;</p> <p>(f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation;</p> <p>(g) Whether changes to policy, procedures, or guidelines are required; and</p> <p>(h) Whether there are additional education or training needs or changes required to existing education.</p>	CI	A quality improvement project has been implemented around reducing restraint.	In 2018, Avonlea, alongside the senior management team developed a goal to reduce the use of restraint. Three main areas of focus were identified. Processes including increasing staff awareness of detailed patterns of behaviour. This was implemented by ensuring increased oversight, focus and attention by the clinical manager and registered nurses. When staff were familiar with resident needs and patterns, their individual needs can be anticipated, and behaviours can be immediately addressed before they escalate. Staff training at induction and orientation included De-escalation and Disengagement Training as well as annual and refresher training. Where staff experienced difficulty with managing behaviours, they were able to seek additional support and case management from the National Mental Health Nurse. This was a new position created in 2016 to support complex client behaviours nationally. The NMH Nurse reports directly to the National Clinical Manager who monitors restraint at clinical governance/organisational level. As a result of these measures restraint has continually reduced from seven in 2019, to five in 2020 and there are currently two residents on restraint.

End of the report.