Millvale House Waikanae Limited - Millvale House Waikanae

Introduction

This report records the results of a Certification 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: 30 November 2017 End date: 7 December 2017

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 24

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

Millvale Waikanae provides dedicated psychogeriatric hospital level care for up to 30 residents. On the day of audit, there were 24 residents at the facility.

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 relatives, general practitioner, management and staff.

The quality and risk management plan is implemented and monitored and this generates improvements in practice and service delivery. Key components of the quality management system link to monthly quality meetings and monthly staff meetings. The quality management system has continued to result in improved outcomes for residents.

The operational manager position has recently been disestablished and a new administration position developed. The newly appointed administrator was being orientated during the audit period. The operations manager at the sister facility, approximately 10 minutes' drive from Millvale House Waikanae has provided support to the facility manager, formally the clinical manger, during the time the operations manager position was dis-established, and the administrator was appointed. The DCNZ senior management team, including the national clinical manager provide strong support at Millvale House Waikanae.

The service is commended for achieving a continued improvement rating around good practice and quality improvement projects.

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.		All standards applicable to this service fully attained with some standards exceeded.

Millvale House Waikanae provides care in a way that focuses on the individual resident. Cultural and spiritual assessments are undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code of Rights and related services is readily available to families. A site-specific introduction to the dementia unit booklet provides information for family, friends and people visiting the facility. Residents and family interviewed verified on-going involvement with the community. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

Organisational management

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

Millvale House Waikanae is implementing the Dementia Care NZ quality and risk management system that supports the provision of clinical care. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. There is strategic plan for 2015-2018 and a business plan for 2017-2018 in place for all DCNZ facilities. Incidents and accidents are appropriately documented and managed. There are human resources policies including recruitment, job

descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is a well-developed education programme in place that is supported from the head office. This includes training packages for all nursing staff. External training is supported. Staff requirements are determined using an organisation service level/skill mix process and documented. There is a documented rationale for staffing. Staffing rosters indicate there are suitable staff on duty to care for 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.

There are pre-entry and admission procedures in place. There is a well-presented information booklet for residents/families/whanau at entry that includes information on the service philosophy and practices particular to the service. Care plans are developed by registered nurses and are reviewed six monthly or sooner where necessary by the multidisciplinary team. Families are involved in the development and review of the care plans. A multi-disciplinary review occurs six monthly. The service has strong vision that is reflected in a multidisciplinary collaborative team approach that assists with clinical decision making. All assessments are linked into the comprehensive care plan. A 24-hour multidisciplinary care plan identifies residents' 24-hour requirements.

There is at least a three-monthly resident review by the medical practitioner, geriatrician and/or psychogeriatrician. There is a planned seven days activities programme that is developed by diversional therapy staff that includes daily household activities, reminiscing and sensory activities.

The medication management system includes medication policy and procedures. Education and training of staff in relation to medicine management has been completed by staff. All electronic medications charts have current identification photos and special instructions for the administration/crushing of medications. There is a reduction of psychotropic medication programme in

place. One of the two general practitioner's (GP) reviews the resident's medication at least three monthly. Medication reconciliation is completed 3 monthly by a pharmacist.

All cooking and baking is done on site. Nutritional snacks are available over a 24-hour period. A dietitian visits monthly for review of resident nutritional status and needs and notes are included in resident files. The menu has been reviewed by the dietitian. Special diets are identified, recorded in the kitchen and delivered and monitored for effectiveness onsite.

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 service has waste management policies and procedures for the safe disposal of waste and hazardous substances. The service has a preventative maintenance programme. There is a current building warrant of fitness.

Millvale House Waikanae is run as one singular unit, divided into two small homes. Their philosophy of the 'small homes' means that the environment feels more normalised, and residents orientate to their environment more easily. The facility is well maintained with easy access to the secure gardens and paths. Residents are able to move freely inside and within the secure outside environment.

There are two dining and lounge areas. Residents/visitors are able to access other areas for privacy if required. Furniture is appropriate to the setting and arranged to enable residents to mobilise. There are several communal areas, and activities can occur in the lounges and/or the dining area or other areas as required. The service has in place policies and procedures for effective management of laundry and cleaning practices.

The service has implemented policies and procedures for civil defence and other emergencies. There is staff on each duty with a current first aid certificate. Fire drills are conducted six monthly and the fire service has approved the evacuation scheme.

General living areas and resident rooms are appropriately heated and ventilated.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. On the day of the audit there were five residents on the register assessed as requiring intermittent restraint (one bed rail, one lap belt and three residents with T belts). There are no residents with enablers. A register is maintained by the restraint coordinator/RN. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

Infection prevention and control

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

The infection control management systems are well documented and implemented to minimize the risk of infection to consumers, staff and visitors. The infection control programme is monitored for effectiveness and linked to the quality and risk management plan. There is a comprehensive orientation and education programme for all staff. Infection rates are monitored and benchmarked

with other facilities within the organisation. Benchmarking also occurs through clinical governance and the results of review/analyses are used to identify any service shortfalls and infection control effectiveness.

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	49	0	0	0	0	0
Criteria	2	99	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Millvale House Waikanae has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Care staff interviewed, including four caregivers, two diversional therapists and two registered nurses (RN) were able to describe how they incorporate resident choice into the resident's activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with four relatives.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make	FA	There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. Residents have a medical guidance plan that covers admission to hospital and resuscitation. There is evidence of EPOA/GP and clinical manager participation in the medical guidance plan. Interviews with staff and families supported that they have input and are given choices. Care plans, ADLs and 24 hours multidisciplinary care plans demonstrate resident choice as appropriate.

informed choices and give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is regularly discussed at resident/relative's meetings (minutes sighted). The service provides opportunities for the family/EPOA to be involved in decisions.
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	Interview with relatives confirm that visiting can occur at any time and families are encouraged to be involved with the service and care. Residents are supported to maintain former activities and interests in the community if appropriate.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. There are complaint forms and information available at the entrance. Information about the complaints process is provided on admission. Care staff interviewed were able to describe the process around reporting complaints. An established complaints register is included on an access database format. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response. Seven complaints have been made in 2016 and one complaint received in 2017 year to date. All complaints reviewed had documented evidence of appropriate follow-up actions and resolutions taken. Timeframes for addressing each complaint are compliant with the Health and Disability Commissioner (HDC) guidelines and corrective actions (when required) are documented.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability (HDC) Commission. Relatives are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement. Relatives interviewed confirmed they received all the relevant information during admission.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms. Relatives interviewed confirmed staff respect their privacy, and support residents in making choice where able. Staff have completed education around privacy, advocacy, abuse and neglect. Resident files are stored securely. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	Dementia Care NZ Ltd has a Maori health plan which has been recently reviewed, and a cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Residents who identify as Maori have this recorded on file with an individual health care plan developed in partnership with whanau to meet individual Maori cultural requirements. Linkages with Maori community groups are available and accessed as required such as Ataiwa Ki Whakarongatai Charitable Trust. At the time of the audit there was one resident who identified as Maori.
Standard 1.1.6: Recognition And Respect Of The	FA	Family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the resident needs are being met. Discussion with family confirm values and beliefs are

Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		considered. Family/resident newsletters are provided quarterly.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the seven staff files sampled. Staff complete confidentiality and the code of conduct training. The RNs and allied health professionals practice within their scope of practice. Interviews with RNs and care staff confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	Millvale House Waikanae policies and procedures meet the health and disability service sector standards. An environment of open discussion is promoted. Staff report that the senior staff are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The RNs have access to external training. Internal and external professional development is provided and encouraged. Discussions with family were positive about the care they receive. A quality monitoring programme is implemented which monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through (but not limited to) relatives meeting, quality meetings, infection control meetings, health and safety meetings, staff appraisals, satisfaction audits, internal audits, complaints and incident management. Relatives interviewed spoke positively about the care provided and were well informed and supported. There are implemented competencies for all staff including caregivers, and RNs. There are clear ethical and professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication Service providers	FA	There is an open disclosure policy in place, information on which is included at the time of admission. A site-specific introduction to the psychogeriatric unit booklet provides information for family, friends and visitors visiting the facility. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts

communicate effectively with consumers and provide an environment conducive to effective communication.		staff to their responsibility to notify family/next of kin of any accident/incident. Sixteen incidents/accidents forms were reviewed for October 2017. The form includes a section to record family notification. All sixteen incident/accident forms indicate family are informed. Relatives interviewed confirmed they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Dementia Care New Zealand Limited (DCNZ) is the parent company under which Millvale House Waikanae operates. Millvale House Waikanae provides psychogeriatric level care for up to 30 residents. There were 24 residents in the home on the day of audit. All residents were under the ARHSS contract. DCNZ has a corporate structure in place which includes the three directors and a governance team of managers and coordinators. The operations management leader and national clinical manager support the facility manager. The vision and values of the organisation underpin the philosophy of the service. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their change in cognition. There is strategic plan for 2015-2018 and a business plan for 2017-2018 in place for all DCNZ facilities. The 2017 organisational goals have been reviewed by the governance team, company clinical director, operations management leader, quality systems manager, company mental health nurse /educator and marketing and public relations manager. The facility manager is responsible for the daily clinical and non-clinical operations of the facility with support from the administrator. The newly appointed administrator was completing the orientation programme at the time of the audit. The facility manager has been employed at the facility for 18 months. The operations manager from Millvale Lodge Lindale was present on the day of the audit. An organisational operations management leader, national clinical manager, quality systems manager, company clinical director, company mental health nurse/educator and directors regularly visit the facility and provide support to the team at Millvale House Waikanae. The clinical director, national clinical manager, quality systems manager and company mental health nurse/educator were present during the day of the audit. The organisation holds biannual training days in Christchurch for all operations managers and biannual 3-day conferences in Christchurch in advance nursing practice for all clinical managers.
Standard 1.2.2: Service Management The organisation	FA	During a temporary absence of the facility manager, a senior registered nurse takes over facility responsibility with support of a sister facility clinical manager, the national clinical manager and the DCNZ clinical director.

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.		
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The organisation wide quality and risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management plan is monitored through the quality meeting. The facility manager logs and monitors all quality data. Meeting minutes are maintained, and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Quality improvement (QI) reports are provided at the monthly quality meeting (also link 1.1.8.1). Staff interviewed confirmed involvement and feedback around the quality management system. Data is collected on complaints, accidents, incidents, infection control and restraint use. Benchmarking with other DCNZ facilities occurs on data collected. A national policy and document development and review group was established in 2015. The group is responsible for all aspects of policy development, policy requirements and control. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The internal audit schedule for 2017 is being completed. Areas of non-compliance identified at audits have had corrective action plans developed and signed as completed. The service has an implemented health and safety management system. There are risk management, and health and safety policies and procedures in place including accident and hazard management. There is an annual satisfaction survey last completed in October 2016. Overall results report that residents and relatives are satisfied with the service. Falls prevention strategies are in place that includes assessment of risk, medication review, assessments with physiotherapy input, 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.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or	FA	The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required. Sixteen incident forms reviewed identified they were fully completed and followed up appropriately by the RN. Minutes of the monthly quality meeting, health & safety meetings and RN/clinical meetings reflected a discussion of incidents/accidents and

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.		actions taken. Discussions with the administrator and facility manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. One section 31 notification was completed since the last audit. The notification was for a missing resident.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are human resources policies to support recruitment practices. Six staff files sampled (one facility manager, one RN, two caregivers, one diversional therapist and one cook) contained all relevant employment documentation. Current practising certificates were sighted for the RNs and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. There are 21 caregivers employed across the service. Seventeen have completed the required dementia unit standards. Four caregivers are in the process of completing and all four have been employed for less than 12 months. There is an education plan in place that covers compulsory education requirements and includes programmes designed and implemented by the service. The "best friends approach to dementia care" programme is designed to support caregivers and RNs to adopt a best friend approach to residents with dementia. Regular “Best Friends Approach to Dementia Care” (putting yourself in their shoes) training is carried out for all staff. There are five RN’s and all of them have completed interRAI training. The facility manager has also completed interRAI training. Clinical staff complete competencies relevant to their role.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The facility manager is on-site full time and is available for on call after hours. The facility manager is supported for 12 hours per week by the administrator. The psychogeriatric unit is split in to two wings, the Tui wing (13 of 15 residents) and Kereru wing (11 of 15 residents). In the Tui wing there is one RN on duty in the morning and afternoon shifts, and on the night shift. Three caregivers (two long and one short shift) rostered on the morning shift, three caregivers (two long and one short shift) on the afternoon shift and one caregiver on the night shift. In the Kereu wing there are two caregivers (long shift) rostered on the morning shift, two caregivers (one long and one short shift) on the afternoon shift and one caregiver on the night shift. Extra staff are called on for increased resident requirements.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant caregiver or RN including designation. Files are integrated.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There are pre-entry and admission procedures in place. Residents are assessed on entry to the service and needs assessments are sighted on the six resident files sampled. The service liaises with assessment services and service coordinators as required. The service is pro-active in the community and maintains good relationships with groups such as Alzheimer's Society and Age Concern. The service has a well-presented information booklet for residents/families/whanau at entry. It is comprehensive and designed so it can be read with ease (spaced and larger print). Family members interviewed stated they received sufficient information on the services provided and are appreciative of the staff support during the admission process.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a discharge planning and transfer policy and resident transfer to hospital (acute) policies to guide staff in this process. Discussions with the service confirmed that resident exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of residents' care through the completed internal transfer form, copy of relevant progress notes, copy of medication chart and doctor's notes. A yellow envelope and checklist is used for transfers to the hospital. A staff member accompanies residents to the hospital if no family are available.
Standard 1.3.12: Medicine	FA	The medication management system includes policy and procedures that follow recognised standards and guidelines for safe medicine management practice. The RN on duty checks medications on delivery against the

Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		medication charts. A tracking sheet with all stock medication expiry dates has been developed and implemented. All medications in stock were within the expiry dates. RNs only administer medications and they have completed annual medication competencies and medication education. There were no self-medicating residents. The standing orders meet legislative requirements. All medications are stored safely. The medication fridge temperature is monitored. All eye drops, and eye ointments sighted in the medication trolley were named and dated. All 12 electronic medication charts reviewed had photo identification and allergies noted. Medications signed as administered corresponded with the medication chart. The 12 medication charts had been reviewed by the GP at least three monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a cook on duty Monday to Sunday 7.00 am – 5.15 pm. a kitchen aid on duty support the cook each evening. A dietitian has audited and approved the four-week menu. All baking and meals are cooked on-site in the main kitchen. The kitchen is located between the two wings with serveries to each dining room. The kitchen is a secure area accessible to staff only. The cook (interviewed) receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in kitchen. Special diets such as diabetic desserts, vegetarian, pureed meals and alternative choices for dislikes are accommodated. High protein drinks and foods are readily available. Finger foods and nutritious snacks (sighted) are available 24 hours. The dietitian visits at least monthly. A daily log is maintained of end cooked food temperatures, fridge and freezer temperatures. Temperatures are recorded on all chilled and frozen food deliveries. All foods in the chiller, fridges and freezers are dated. Chemicals are stored safely. Cleaning schedules are maintained. Food services staff have completed food safety unit standards.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their	FA	The reason for declining service entry to residents is recorded should this occur and communicated to the resident/family/whanau. The facility manager reported that the referring coordinator would be advised when a resident is declined access to the service and it is then their responsibility to inform the resident/family/whanau of other options that may assist them to meet their needs. At the time of the audit there were six beds available at the facility.

family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The information gathered at admission and health assessment form is used to develop care needs, aims and actions to provide best care for the residents. Resident files sampled had current interRAI assessments completed. There are other allied health assessments completed such as dietitian assessment and physio assessment. The diversional therapist also completes a comprehensive social assessment that includes identifying diversional, motivation and recreational requirements. EPOA's are involved in the assessment process as confirmed by family members interviewed. Files sampled demonstrated that outcomes of assessments, including the interRAI assessment are included in the current care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans are developed and reviewed by the RN's. The care plans sampled were comprehensive and include all identified resident needs and includes diagnosis/needs, aim and action. Care plans sampled reflected the outcomes of assessments and addressed current abilities, level of independence, identified needs and specific behavioural management strategies. All six residents had comprehensive behaviour management plans. The DT and RN complete a 24-hour MDT (multidisciplinary) care plan. The MDT care plan details the resident's morning and afternoon habits, behaviours, activities or diversions that work, nocte pattern, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation. The activities person and/or family complete a resident activity profile sheet. The activity care plan identifies the resident's individual values, beliefs, spirituality and culture. Short-term care plans are being utilised for short-term needs. Short-term care plans were sighted in resident files sampled for any acute or new needs. Each resident file has an interventions/special instructions form placed on the front of the file. Resident handling plan and ADL guides are placed inside each resident's wardrobe for quick reference for caregivers. Service delivery plans demonstrate service integration.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services	FA	The care provided is consistent with the needs of residents as demonstrated in the review of the care plans and in discussion with caregivers, registered nurses, activity staff and management. Families interviewed stated their relative's needs are being met. The RN initiates a GP or nurse specialist consultation when a residents' condition changes. Families confirmed they are notified promptly of any changes to health status. Families meet with onsite clinicians and nurse specialists regularly Wound assessments and evaluations have been completed for 15 minor wounds – one resident has nine wounds

in order to meet their assessed needs and desired outcomes.		(link tracer), one resident has four and one resident has one wound. There were no pressure injuries at the time of the audit. The GP, dietitian and physiotherapist have been involved in the wound care of previous pressure injuries. Specialist wound and continence management advice is available as needed and the facility manager and RN (interviewed) could describe this. Continence assessments, including a urinary and bowel continence assessment, are completed on admission and reviewed three monthly. The company has a continence resource person. Pain assessments are completed for all residents with identified pain and on pain relief. Abbey pain assessments are completed for all residents unable to express pain. Pain monitoring forms used to monitor the effectiveness of pain relief are kept in the medication chart folder. Challenging behaviour assessments are well documented with amendments made to the care plan as required. The company has two newly developed roles; Mental Health Nurse (2016) and Mental Health Advisor (2017) who support, advise and educate staff. There is a wide range of specialist input into the resident's care. The staff interviewed could describe strategies for the provisions of a low stimulus environment. The caregivers stated they have the equipment available to safely deliver care as documented in the resident care plans including hospital ultra-low beds, sensor mats, hoists and chair scales.
Standard 1.3.7: Planned Activities 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.	FA	The diversional therapy team of three provide a seven day a week activity programme in the afternoons and evenings. One of these is a trained diversional therapist, and one of the three positions was being recruited at the time of the audit. The two current activities staff hold a current first aid certificate and attend on-site education including challenging behaviours. Care staff on duty are involved in individual activities with the residents as observed on the day of audit. There are resources available to staff for activities. The programme observed was appropriate for older people with mental health conditions and dementia. Activities were observed to be occurring in the lounge of each wing simultaneously. The programme is focused on individual and small group activities that are meaningful including household tasks, reminiscing and sensory activities such as massage and foot spas, gardening, walks, games, music and movies. Files sampled evidenced that activity assessments, activity plan, 24-hour MDT care plan, progress notes and attendance charts are maintained. Family meetings are held. A comprehensive social history is completed on or soon after admission and information gathered from the relative (and resident as able) is included in the activity care plan. A 24-hour MDT care plan is reviewed at least six

		monthly.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	In the files reviewed, initial care plans were evaluated by the RN within three weeks of admission. In four of the six files reviewed, nursing care plans are reviewed three monthly by the multidisciplinary team (MDT) and evaluated at least six monthly or earlier when required due to health changes. Two residents had not been at the service for three months. Families interviewed confirmed that they are invited to the three-monthly MDT reviews. Other health professionals are involved as appropriate such as the physiotherapist and dietitian. Short-term care plans are utilised for short-term needs and reviewed as required with any ongoing problem added to the long-term care plan. Ongoing nursing evaluations occur daily/as indicated and are included within the progress notes.
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 services (medical and non-medical) and where access occurs referral documentation is maintained. There is regular communication with the mental health for the older person's team and the psychogeriatric services. Family/whanau/EPOA are involved as appropriate when referral to another service occurs. Referrals sighted in the resident files sampled include hospice, dietitian, physiotherapist, psychogeriatrician, wound care specialist and district nurse.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of	FA	The service has in place management of waste and hazardous materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. There is an incident reporting system that includes investigation of these types of incidents. Chemicals are labelled correctly and stored safely throughout the facility. Appropriate personal protective equipment was sighted throughout the facility. The chemical supplier provides safety data sheets and conduct quality control checks on the effectiveness of chemicals. Waste management contractors deliver and collect the skips bins. Recycling of plastics occurs. Approved containers are used for the safe disposal of sharps. Staff interviewed were able to describe waste management and chemical safety procedures.

exposure to waste, infectious or hazardous substances, generated during service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Millvale Waikanae has a current building warrant of fitness that expires on 12 June 2018. The entrance to the building is secure. There is call bell access outside of office hours. The facility has multiple living and lounge areas and divided into two "homes" which are Kereru (15 beds) and Tui (15 beds). There is push button access between the two areas. Residents are able to move freely around the entire facility. Doors from the internal dining rooms and lounges open out onto a safe internal courtyard, gardens and shaded seating areas. There are a number of safe walking paths that lead back into communal lounges and conservatory areas of either "home". The external grounds are fully fenced and secure. Fences are high, and care has been taken to ensure that residents are not able to use furniture etc to climb fences, including that outdoor furniture is bolted down. There has been one section 31 reported since the previous audit for a missing resident. The place where the resident exited the facility had a six-foot-high fence with vertical palings and an area of busy trees on the other side of the fence. This would be difficult for most people, especially aged people to traverse. The resident concerned was reported to have used a walker to assist them in climbing the fence. Both 'homes' are spacious and wide corridors allow for the use of mobility equipment. Maintenance including reactive and preventative maintenance is managed from head office and external contractors are used. Clinical equipment is checked for function and calibrated annually. The maintenance person completes weekly hot water temperatures in resident areas rotating the areas weekly. Temperatures are maintained at 40-45 degrees Celsius. Staff interviewed reported that all equipment required to meet residents' needs is available.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene	FA	One bedroom has an ensuite. All bedrooms are single and have hand basins. There are adequate numbers of showers and toilets within the facility. Fixtures, fittings and floor and wall surfaces are made of accepted materials for meeting hygiene and infection control practices and resident safety. Communal toilets and showers have occupied /vacant signs on the doors. Shower rooms have and privacy curtains. There are appropriately placed handrails in the bathrooms and toilets.

requirements or receiving assistance with personal hygiene requirements.		
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Residents' rooms are of sufficient space to allow services to be provided and for the safe use, mobility aids and hoist if necessary. The bedrooms are personalised. The bedrooms environment is uncluttered. Electric beds or ultra-low beds are available for use. There is a mix of bedrooms with carpet and lino flooring. Wardrobes are fixed to the wall.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Each "home", Keneru and Tui, have spacious dining and lounge areas with access to the outdoor areas. Other small seating alcoves can be accessed from internal and external walking pathways. A smaller activity/visitor/quiet room is available for use. Activities take place in the dining room or lounge area of each unit dependent on the type of activity. Seating and space is arranged to allow both individual and group activities to occur
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services	FA	The service has in place policies and procedures for effective management of cleaning and linen practices. The facility manager oversees the laundry and cleaning services. The caregivers carry out the laundering of the linen and personal clothing. A restructure implemented between the first and second days of the audit means that 'home assistants' now complete laundry and cleaning duties. The cleaner's chemical system is kept within a locked area. The cleaner's equipment and chemicals are not left unattended when carrying out the cleaning duties. Protective equipment is available in the laundry and sluice room. Feedback on the service is received through internal audits, meetings and

appropriate to the setting in which the service is being provided.		surveys. The chemical supplier completes regular audits on the laundry and cleaning practices, efficiency of equipment and effectiveness of chemical use. Families interviewed were very satisfied with the cleanliness of their relative's rooms and the care taken with personal clothing.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted, with the last fire evacuation drill occurring on 10 August 2017. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Civil defence boxes are available in each wing (sighted) and are checked monthly. There is a civil defence cupboard, pandemic/outbreak supplies and civil defence kit available and the emergencies supplies are checked monthly. Emergency equipment is available at the facility. The service has alternative gas facilities (BBQ) for cooking in the event of a power failure, with a backup system for emergency lighting and battery backup. There is food stored in the kitchen for three days. There is more than sufficient water stored (1,200 litres) to ensure for three litres per day for over a week per resident. Short-term back up power for emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents' rooms, and lounge/dining room areas.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and resident rooms are appropriately heated with under floor heating. There is bathroom heating. Bedroom windows open safely. Family members interviewed stated the home environment is comfortable. Residents have access to natural light in their rooms and there is adequate external light in communal areas.
Standard 3.1: Infection control management	FA	The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is a job description for the infection control coordinator with clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk

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.		management system. The DCNZ clinical governance group is responsible for the development of the infection control programme and its annual review, Millvale House Waikanae infection control nurse and IC committee are responsible for the implementation of the infection control programme and the evaluation of the programmes objectives. There are infection control meetings held regularly that comprise of the infection control nurse, facility manager, cook and care staff. Information from these meetings is communicated to the clinical meetings. The facility has adequate signage and hand sanitizers at the entrance. Notices for visitors asking them not to enter if they have been in contact with infectious diseases have been ordered to place at the entrances.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The monthly infection control committee meeting includes discussion around all relevant infection control issues. The IC committee is made up of a cross section of staff from across the service. The service also has access to an IC consultant, Public Health Unit, Wellington Public Hospital IC Nurse GP's and the CCDHB infection control nurse specialist.
Standard 3.3: Policies and procedures 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	FA	The infection control manual outlines a comprehensive range of current policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC team, training and education of staff. Policy development involves the organisation IC nurses, the infection control committee and expertise from the regional clinical managers, quality and systems manager, and consultant microbiologist from Southern Community Laboratories.

the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control nurse is responsible for co-ordinating/providing education and training to staff and is supported by the facility manager. There are internal and external sessions available for training. The IC nurse has attended a study day at the DHB. The facility manager has attended 6 hours annual external IC expert education.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The IC nurse uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and the DHB infection control team who advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. Infection control data is collated monthly and reported to the monthly infection control meeting. Infections are documented on the infection monthly register. The surveillance of infection data assists in evaluating compliance with infection control practices. The IC programme is linked with the quality and risk management programme. The service benchmarks with other DCNZ facilities. Analysis of trends is included in infection control meetings and an action plan is established if required. IC data is reviewed at DCNZ clinical governance and action taken in response to potential service gaps. Evidence was sighted to demonstrate the service has implemented interventions resulting in a very low rate of UTI’s (nil for two months in 2017 YTD).
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with caregivers and nursing staff confirm their understanding of restraints and enablers. The service completes assessments for residents who require appropriate restraint intervention and it reviews past assistance / interventions. Care plans include a full description of the approved restraint intervention and monthly

restraint is actively minimised.		evaluation. There are five residents on the register assessed as requiring intermittent restraint (one bed rail, one lap belt and three residents with T belts). There are no residents with enablers. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.
Standard 2.2.1: Restraint approval and processes 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 others.	FA	The restraint coordinator is a RN who is experienced in dementia care. The restraint approval process and the conditions of restraint use are recorded on the "restraint risk assessment consent and management form". A restraint approval group meeting is held six monthly where the restraint approval process and the associated policies are discussed. Consent for restraint use is logged in the restraint register. Suitably qualified and skilled staff such as the RN and GP in partnership undertakes assessments with the resident and their family/ whanau. Restraint use is monitored monthly at registered nurse meetings.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The service completes assessments for residents who require appropriate restraint or enabler intervention. Suitably qualified and skilled staff in partnership with the family/whanau undertakes these. Restraint risk assessment, consent and management form is completed and signed by the resident rep (family / EPOA), RN, and GP. This was documented in the three resident files reviewed of residents requiring restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint policy requires that restraint is only put in place where it is clinically indicated and justified. The policy requires that restraint, if used, be monitored closely and this is done daily using a monitoring form. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. The risk assessment, consent, and management form addresses this criterion and the restraint intervention is fully described in the care plans reviewed

		with daily monitoring records completed by staff.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Three files were reviewed of residents requiring restraint. The use of restraint episodes are evaluated three monthly as part of the GP review. All episodes of restraint are also monitored monthly through the RN meeting. A six-monthly resident minimisation group reviews all episodes of restraint use and a report is provided to the service and senior teams.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint coordinator is a RN. The restraint minimisation committee at meet six monthly to review restraint use. An annual audit is completed on restraint use. Monthly reviews as part of the RN meeting are well documented.

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 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	CI	Millvale Lodge Waikanae has a business plan, quality plan, health and safety plan and infection control plan. A quality monitoring programme is implemented which monitors contractual and standards compliance and the quality of service delivery. Benchmarking with other Dementia Care NZ facilities with psychogeriatric level care occurs around infections, health and safety (manual handling, skin tears, medication errors, resident falls, resident accidents) and clinical record audits. At service level, incident/accident reports are collated. Analysis of trends occurs, and comprehensive monthly reports are written including ongoing review and analysis of corrective actions. Corrective action status is monitored and evaluated for effectiveness/signed out. This is reflected in comprehensive reports forwarded to the Dementia Care NZ monthly meeting (sighted). There are a number of quality	The achievement of the rating that service provides an environment that encourages good practice is beyond the expected full attainment. The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects include reviewing if the improvements have had positive impacts on resident safety or resident satisfaction. Example In 2016, there was an average of 0.83 medication errors a month. A targeted education, training and monitoring approach was introduced after setting a goal of ‘no medication errors across 2017’. Through a series of opportunistic and dedicated meetings/sessions on medication delivery and management, staff became focussed on the core safe skills required in a complex working environment. No

		improvement (QI) projects running and all staff and families are encouraged and facilitated to have input in to the quality improvement activities. QI's are raised as a result of feedback, complaints, surveys, staff or management suggestions, ideas and discussions at handover. Once completed the QI's are logged in the six-monthly statistics for health and safety/infection control/quality. There is a quality and risk management plan for 2017. The plan is reviewed monthly at quality meetings to measure progress towards meeting the programme objectives.	medication errors have been reported in 2017 since the project started. Other projects include reducing resident behaviours and skin tears are effectively being monitored and evaluated.
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	A falls reduction/prevention project has been identified as a group wide initiative and is being implemented at Millvale House Waikanae. The aim of the project is to minimise fall incidents in each facility. The rate of falls within each unit is gathered monthly, as part of benchmarking clinical indicator data.	The falls reduction project implemented at Millvale House Waikanae included; working with family the symptoms of dementia, associated risks and outcomes, the use of falls mapping to identify high risk times of the day, collaboration with the physiotherapist to establish strategies for at risk residents, a register of residents on vitamin D has been set up and updated monthly, use of sensor mats, working with the diversional therapist to offer distraction to reduce the desire to mobilise when it is unsafe and regular staff falls prevention training provided. The outcome of the falls minimisation project has resulted in annual average fall rate of 8.61 (per 1000 bed days) in 2017 compared to 13.82 (per 1000 bed days) for 2016, a reduction of 5.21 (per 1000 bed days).

End of the report.