Millvale House Levin Limited - Millvale House Levin

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 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 Levin Limited
Premises audited:	Millvale House Levin
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric)
Dates of audit:	Start date: 13 December 2017 End date: 14 December 2017

Proposed changes to current services (if any): The service is adding rest home level care to their current certification. The current empty wing of 12 hospital level beds will be utilised as dual-purpose beds. They are also increasing the psychogeriatric level service from 16-18 beds. By converting back into bedrooms, two rooms that have been used for other purposes (these rooms were previously certified).

Total beds occupied across all premises included in the audit on the first day of the audit: 16

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Dementia Care New Zealand Ltd is the parent company of Millvale House Levin. The service provides psychogeriatric level care and hospital (geriatric and medical) care level care for up to 30 residents. On the day of audit, there were 16 residents. The current 12-bed hospital wing was empty due to refurbishments.

The certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents' and staff files, observations and interviews with relatives, staff and management. In addition, a partial provisional audit was completed to verify the preparedness of the service to provide rest home level care. The current empty wing of 12 hospital level beds will be utilised as dual-purpose beds.

The quality and risk management plan is being implemented and monitored. Key components of the quality management system link to monthly quality meetings.

A facility manager (RN) and an operations coordinator are responsible for the daily clinical and non-clinical operations of the facility. The facility manager has been in the role for the last 18 months and has previous nursing experience in mental health.

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

The following improvements have been identified at this audit in relation to the partial provisional audit around staffing, completing the landscaping and furniture.

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 Levin 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 easily 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.

Millvale House provides care in a way that focuses on the individual resident. 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 and related services is readily available to residents and families. A site-specific introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

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.		Some standards applicable to this service partially attained and of low risk.

Dementia Care NZ has an established clinical governance group. The service has a well-established quality and risk management system. There were a number of quality initiatives completed at a facility and organisational level. The quality system includes (but not limited to): feedback from the family members with post six-monthly surveys; complaints management system; audit results; and staff and quality meetings.

Incident/accidents are documented. Reporting of incidents occurs and has been monitored with action taken on trends to improve service delivery.

Human resources policies and procedures were implemented. A comprehensive orientation programme provides new staff with relevant information for safe work practice.

There is a comprehensive in-service programme in place, including (but not limited to) specific training around “Best Friends Approach to Dementia Care” and specific behaviour management training.

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

Continuum of service delivery

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

A comprehensive information booklet is available for residents/families at entry which includes information on the service philosophy, services provided and practices to the secure unit. There are pre-entry and admission procedures in place. Care plans are developed by registered nurses and are reviewed by the multidisciplinary team. Families are involved in the development and review of the care plan. A multidisciplinary nursing, activities and GP resident review occurs three-monthly. Assessments are linked into the comprehensive care plan.
The activity team develop a programme to meet the recreational needs and preferences of each consumer group. There is a flexible and resident-focused activity plan over seven days a week in the dementia unit. Individual activity plans are developed in consultation with residents and family.
All medications charts have current identification photos and special instructions for the administration/crushing of medications. The GP reviews the resident's medication at least three-monthly.
The service has contracted to work with a dietitian monthly for review of resident nutritional status and needs, and notes are included in resident files. The menu is reviewed by the organisational dietitian.

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.

The building has a current building warrant of fitness. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. First aid training has been provided for staff and there is at least one staff member on duty at all times with a first aid certificate. There is an approved fire evacuation plan. The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. All chemicals are stored safely. There is a planned maintenance schedule. There is adequate space in the facility for storage of mobility equipment. Resident's rooms, lounge areas and the environment are suitable for the current needs of the residents. Outdoor areas are safe and secure and accessible for the residents. There is adequate equipment for the safe delivery of care. All equipment is well maintained. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff regularly receive training in emergency procedures.

Residents in Aroha Nui, the PG unit are able to move freely inside and within their secure environment.

Restraint minimisation and safe practice

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

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. There are seven residents using restraints and no residents utilising enablers. A register is maintained by the restraint coordinator/registered nurse (RN). Residents using restraints are reviewed a minimum of six-monthly by the approval group. 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 programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (facility manager) is responsible for coordinating/providing education and training for staff. Infection control training has been provided within the last year. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Dementia Care NZ (DCNZ) facilities.

Summary of attainment

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

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	46	0	3	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	Millvale House has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Seven care staff interviewed (four caregivers, one activity coordinator and two registered nurses) 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 informed choices and give informed consent.	FA	There are established informed consent policies/procedures and advanced directives. Files sampled demonstrated that general consent had been obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. In files sampled, residents had a medical guidance plan that covers admission to hospital and resuscitation with evidence of enduring power of attorney (EPOA), general practitioner and clinical manager participation. Medically indicated 'not for resuscitation' status forms evidenced discussion with the EPOA/family. The GP or specialists had completed letter of mental capacity for residents.

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 residents and family confirmed they are aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is regularly discussed at resident/relatives' meetings (minutes sighted). The service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the residents' family and chosen social networks.
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 in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. Complaints information is available at the entrance and information is provided to residents and relatives at entry. An established and up-to-date complaints register is also included on an access database format. The database register includes a logging system, complainant, resident, outline, dates, investigation, findings, outcome and response. Specific QIs are raised from complaints. For 2017 (YTD), there have been three complaints. The complaints were well documented and managed. A complaints procedure is provided to residents within the information pack at entry. A post-admission satisfaction survey identifies if any relatives are unaware of the complaints procedure. The 2016 Welfare Guardian survey resulted in a corrective action by the service around making complaints forms more accessible and feedback was provided to family through the newsletter.
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, dignity and elder protection. 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 Māori 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 Māori have this recorded on file with an individual health care plan tailored to meet Māori cultural requirements. Linkages with Māori community groups are available and accessed as required such as Ataiwa Ki Whakarongatai Charitable Trust. At the time of the audit there were no residents that identified as Māori at Millvale House.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The resident and families 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 residents' needs are being met. Discussion with family confirm values and beliefs are considered. Family/resident newsletters are provided quarterly. Residents are supported to attend visiting church services held on-site.
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 comply with confidentiality and the code of conduct. The registered nurses 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	An implemented quality improvement programme includes performance monitoring. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality of service delivery. The service monitors its performance through resident/relative's meetings, quality meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management. 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. There are a number of quality improvement 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 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. The education programme includes a comprehensive orientation programme with corresponding competency packages. Competencies for all staff include safe food handling, fire and evacuation, cultural safety, safe chemical handling and restraint. Resident and relative surveys are completed annually. Other surveys include a six-week post admission survey, restraint response survey and respite survey. Two PG family members interviewed spoke very positively about the care provided and were well informed and supported. The following improvements have been made across DCNZ and Millvale since previous audit: (i) DCNZ appointment of resource nurses including wound resource nurse and falls coordinator -linked to falls project in 2016 business plan; (ii) Clinical Governance; (iii) Professional development programme for CM's & RNs – Advanced Nursing Practice; (iv) PDDDR (Policy and Document Development and review Group) ensuring good practice congruent between policy and procedure development and review; (v) The development of a national mental health nurse role to include case management for residents with challenging symptoms, expert advice and support; (vi) Introduced a new training programme- Management of Actual and Potential Aggression MAPA
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 staff to their responsibility to notify family/next of kin of any accident/incident.

communicate effectively with consumers and provide an environment conducive to effective communication.		Incidents/accidents forms were reviewed. The form includes a section to record family notification. All incident/accident forms indicated family were 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 Levin operates. Millvale House Levin is certified to provide hospital and psychogeriatric level care for up to 30 residents (currently only the psychogeriatric wing is operational). There were 16 residents in the 18-bed psychogeriatric unit (including 1 ACC and 1 on Like in Age & Interest contract) on the day of audit. The hospital wing was empty due to refurbishments. A facility manager (RN) and an operations coordinator are responsible for the daily clinical and non-clinical operations of the facility. The facility manager has been in the role for the last 18 months and has previous nursing experience in mental health. An organisational operations management leader, national clinical manager, quality systems manager, company clinical director, company educator/psychiatric RN and directors regularly visit the facility and provide support to the team at Millvale House Levin. During the days of the audit the national clinical manager, quality systems manager, company educator /psychiatric RN and one of the directors were present. The vision and values of the organisation underpin the philosophy of the service. The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. There is a strategic plan for 2015-2018 and a business plan for 2017-2018 in place for all facilities. The 2017 organisational goals have been reviewed by the governance team, company directors, clinical director, national clinical manager, quality systems manager, operations management leader and company educator. The organisation holds bi-annual training days for all operations managers and a biannual 3-day conference for all clinical managers. Operations managers have attended at least eight hours of training relevant to their role. Clinical Managers have attended more than 40 professional development hours annually. Partial Provisional: This audit included verifying the preparedness of the service to provide rest home level care. The current empty wing of 12 hospital level beds will be utilised as dual-purpose beds. The audit identified policies, procedures, processes, staffing, environment and equipment are appropriate to provide rest home level care. A transition plan has been developed around the implementation of the new service. The service is also increasing the psychogeriatric level service from 16 to 18 beds. The service is converting two rooms that have been used for other purposes, back into bedrooms (these rooms were previously certified).

Standard 1.2.2: Service Management 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.	FA	During a temporary absence of the facility manager, the operations coordinator and a senior registered nurse assumes the role with support from the DCNZ management team. There are relevant care and support policies including relevant clinical procedures for the management of psychogeriatric and hospital/rest home residents. At Millvale House, there is two house GPs (visit once a week and as needed), physiotherapist (visits one hour a fortnight), podiatrist 8 weekly and a contracted dietitian. Allied health professionals are accessed on an as required basis.
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 risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme is monitored through the quality meeting. The facility manager and operations coordinator log and monitor all quality data. Meeting minutes are maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. QI reports are provided to the monthly quality meeting. A number of meetings includes discussion of quality data and follow through of quality improvements. Staff interviewed confirmed involvement and feedback around the quality management system. Discussions with staff confirmed their involvement in the quality programme. Data is collected on complaints, accidents, incidents, infection control and restraint use. 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. Benchmarking with other facilities occurs on data collected. Surveys are completed including (but not limited to): relatives (welfare guardians), residents, MD services, provider survey and post admission survey. Surveys reviewed included an analysis and QIs developed where needed. The summary report of the 2016 welfare guardian survey included a corrective action plan around the activity programme, food service and complaints. The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. 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. There is an identified site-specific objective as part of the annual H&S plan. Progress to meeting the objective is evaluated through the monthly H&S meetings. Falls prevention strategies are in place that include: assessment of risk; medication review; vitamin D;

		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 untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Discussions with the facility manager confirm an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 reported to HealthCERT. The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Ten incident forms reviewed identified they were fully completed and followed up appropriately by the RN. Minutes of the monthly quality meeting, health and safety meetings and registered nurse meetings reflected a discussion of incidents/accidents and actions taken. A resident event analysis group also meets monthly at Millvale House and reviews all incidents. Internal benchmarking includes an analysis. The service analyses the trends and a comprehensive report is completed that includes outcomes and further actions required at a facility and organisational level.
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.	PA Low	Millvale House employs a total of 22 staff. Staff orientation policy and procedures includes training and support packages for facility manager, clinical manager, registered nurses, caregivers, activities staff, cook and kitchen staff. There are job descriptions available for all positions and staff have employment contracts. Five staff files were reviewed (facility manager, two registered nurses and two caregivers). Job descriptions were evident in all files reviewed. Performance appraisals were up to date. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates was sighted for all registered nurses and allied/medical staff. All five files reviewed showed evidence of orientation to roles with competency packages completed. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Four caregivers interviewed were able to describe the orientation process. Competency packages for registered nurses include (but not limited to): restraint minimisation and safe practice; first aid; ACE dementia series; delirium; syringe driver; medication; neurological conditions; and

		leadership. Caregivers competency package includes (but not limited to): restraint minimisation and safe practice; first aid; taking vital signs; safe medication administration; and leadership. All staff also complete safe food handling, chemical safety, safe manual handling (hoist use), bi-cultural awareness and infection control. There is a spreadsheet of all staff and records all completed orientations, competencies and education attended. There is an in-service calendar currently being implemented for 2017. The annual training programme well exceeds eight hours annually. Additionally, all caregivers are supported to complete the Aged Care Education Certificate Core and Dementia Standards. There are six registered nurses, two have completed interRAI training. There are 13 caregivers, 11 have completed the required dementia standards and 2 are in the process of completing. The diversional therapist has completed the dementia standards. The service implements the organisations programme called 'best friends approach to dementia care', which comprises four x one-hour sessions for caregivers and registered nurses. The programme is part of the annual education plan and includes promoting the approach that care staff are the resident's 'best friend'. The education package includes role-playing and discussions to promote empathy, understanding dementia, communication with dementia residents and providing activities that are meaningful and resident focused. The programme is tied to the vision and values of the organisation. MAPA (management of actual and potential aggression) training is also provided for staff to enable them to safely manage residents with challenging behaviours. Another organisational programme implemented at Millvale House is 'orientation for families' and 'sharing the journey' which is designed for dementia residents' families to provide education, understanding and coping with dementia progression, understanding behaviours, and responding to behaviours. Two family members interviewed confirmed that they felt well supported and appreciated the service's provision of education for them around understanding dementia. Partial Provisional A transition plan has been established that includes the draft roster for the dual-purpose unit. The service is in the process of advertising for new staff (experienced in aged care) for the unit. Some of the current employed staff will be rostered in the unit to support new staff with orientation.
Standard 1.2.8: Service Provider Availability Consumers receive timely,	FA	The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. Rosters are in place and show staff coverage across the psychogeriatric unit. There is a registered nurse on duty in the unit 24/7. Sufficient staff are rostered on to manage the care requirements

appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		of the residents. For the current 16 residents. AM shift RN – 0745- 3.45pm (Mon-Fri this position is held by the FM) Three caregivers – 7am-3pm; 7am-1pm; 9am-12.30pm PM shift RN – 3.15pm – 12.15pm Three caregivers – 3pm- 12am; 4pm-9pm; 5pm-8pm Night shift RN- 12am- 8am DT – 1pm- 5pm across 7 days Interviews staff and family members identify that staffing is adequate to meet the needs of residents. Partial Provisional: There is a draft roster for rest home only and a draft roster for a dual-purpose unit (link 1.2.7.3). Hospital/Rest Home (dual-purpose) draft roster RN- 7am – 3pm Caregiver -7am–12:30pm; DT – 1:30-4:30 RN - 2.45pm-11pm Caregiver - 4:30-8pm RN-11pm-7am Rest Home only draft roster

		Caregiver 7am – 3pm; 7am–12:30pm RN - 8am-10am RN-1pm-3pm DT-1:30-4:30 Caregiver - 3pm-11pm; 4:30-8pm; 11pm-7am
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. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurse's station. Resident records are kept up to date and reflect residents' current overall health and care status. Records can be accessed appropriately by staff. Entries are legible, dated and signed by the relevant staff member including designation. Individual resident files demonstrate service integration. Medication charts are in a separate folder.
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 were sighted in resident files sampled. The service has a well-presented information booklet for residents/families/whānau at entry and includes specific information relating to the PG unit. Family members interviewed stated they received sufficient information on the services provided and are appreciative of the staff support during the admission process. The admission agreements reviewed met the requirements of the ARC contract and included exclusions from the service and examples of how services can be accessed that are not included in the agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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. The service uses the district health board (DHB) 'Yellow' envelope system. A staff member or family member (as appropriate) accompanies the resident to the hospital.
Standard 1.3.12: Medicine	FA	Medication policies and procedures meet legislative requirements. The service uses a robotic system for

Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		regular and PRN medications. An RN checks these on arrival and signs the medication checking form. RNs administer medications with competent senior caregivers assisting as second checkers when required. All staff administering medications have completed an annual competency and education. There is a main locked medication room located in the (currently closed) hospital unit near the office. Staff have to leave the PG unit to access the medication. Medication fridge temperatures are monitored daily. All eye drops in the medication trolleys were dated on opening. An electronic medication documentation system is used. All electronic administration records corresponded with the instructions on the medication chart. 'As required' medications sampled had indications for use documented. All charts had a photo, allergies documented and had been reviewed by the GP three-monthly. There are no self-medicating residents at the facility. Partial Provisional There is one treatment room where medication is stored that will be shared by both units (PG and hospital/rest home) and is located in the dual-purpose unit near the office and entrance to the PG unit. The secure room has two medication trolleys available (one for each unit). RN's or senior caregivers assessed as competent will administer medication for the rest home/hospital residents. Locked drawers are available for those residents who are assessed as competent and wish to self-medicate.
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 an experienced cook working nine hour spilt shifts over six days per week and a caregiver that covers Thursdays. All meals are prepared on-site in the commercial kitchen. Organisational menus are used and these have been reviewed by a dietitian. Special diets are incorporated into the menu. The RN completes a food and nutrition information form on each resident. A copy is received by the cook. The cook reported they are notified of any dietary changes/requirements. All meals are prepared in the main kitchen, plated and transported in hot boxes to the psychogeriatric lounge (which is also used as a dining room). Hot food temperatures and serving temperatures are monitored daily. Resident likes and dislikes are known, and alternative foods are offered. Cultural and spiritual needs are met. Special diets are provided such as vegetarian, diabetic desserts and pureed food. Lip plates and specialised utensils are available as needed to promote independence at meal times. All food sighted in the chiller, freezers and fridges was dated. There is daily fridge and freezer temperature monitoring. There is evidence that there are additional nutritious snacks available over 24-hours for psychogeriatric unit residents. Partial Provisional: The kitchen is located between the PG unit and the dual/purpose unit. There is a combined dining/lounge room that is to be utilised in the dual-purpose unit. Furnishings were not all in place and the service will need to determine how best to arrange furniture including dining tables to meet the need of both rest home and hospital residents that may need assistance (link 1.4.5.1)

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 family/whānau is managed by the organisation, where appropriate.	FA	The reason for declining service entry to potential residents is recorded should this occur and communicated to the potential resident/family/whānau. The clinical manager (CM) stated the referring agency would be advised when a potential resident is declined access to the service.
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. A range of assessment tools are completed on admission and reviewed at least three to six-monthly as applicable. All resident files sampled had interRAI assessments and these had been repeated routinely at least six-monthly and when there was a significant change in needs. Files sampled included allied health assessments completed such as dietitian assessment and physiotherapy. Outcomes from assessments were known and implemented by staff interviewed.
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 RNs. The care plans sampled identified the resident/family member/EPOA who had participated in the development of the long-term care plan. The long-term care plans sampled were comprehensive and had documented interventions for all identified needs. A 24-hour MDT (multidisciplinary) care plan is completed by the diversional therapist and RN. The MDT care plan details the resident's morning, afternoon and night habits, behaviours, activities or diversions that work, usual signs of wellness, indications of change in usual wellness and signs of full distress/agitation. Short-term care plans are used for short-term needs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care being provided is consistent with the needs of residents as demonstrated on the overview of the care plans and discussion with caregivers, registered nurses, activity staff and management. Relatives and residents interviewed stated resident needs are being met. There is one current wound. There is a comprehensive wound assessment, plan and regular reviews documented for the resident who has a chronic venous ulcer. Photos have been taken to monitor progress. Wound management has been assisted with input from the DCNZ wound resource nurse, a wound

		specialist, GP and dietician. Registered nurses reported there is specialist wound and continence management advice available as needed and that adequate dressing supplies and continence products are available. Continence assessments including a urinary and bowel continence assessment, are completed on admission and reviewed three/six-monthly. Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained. Pain assessments are completed for all residents with identified pain and on pain relief. Monitoring forms in use included behaviour monitoring, blood sugar levels, neurological observations, behaviour and vital signs.
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	Millvale House employs a qualified diversional therapist (DT) for four hours a day from 1pm to 5pm Wednesday to Sunday and a caregiver on Monday and Tuesday. The service provides an activity programme designed to meet the needs of psychogeriatric residents. The DT is supported by DTs from other facilities and the senior management team. Varying activities occur and are focused on sensory activities and reflect on daily activities of living such as exercises, crafts, movies, visiting entertainers, garden walks, and music therapy. There is a shared (with another local DCNZ facility) wheelchair van for outings that can transport one wheelchair and three other residents. All van outings are accompanied by two staff, one of whom has a current first aid certificate. A variety of community groups visit the facility. Residents who are unable to participate or choose not to have one-on-one time spent with them including pampering, reading and garden walks. Church services are held weekly. Community church and youth groups visit. Activity assessments, activity plans, 24-hour MDT plans, progress notes and attendance charts are maintained. The activities staff liaise with the family and residents as appropriate to develop the Tree of Life – a history of the resident including their interests and hobbies. Resident meetings are held monthly. There are regular MDT family meetings. Resident files reviewed identified that the individual activity plan is reviewed at the same time as the care plan review. Partial provisional: The diversional therapist is aware of the need for suitable activities for higher functioning residents and has the resources to expand further for rest home/hospital level residents. The service advised that they are planning to employ a further activity person to assist with activities rostered from 1.30pm to 4.30pm Mon-Fri (link 1.2.7.3).
Standard 1.3.8: Evaluation	FA	Care plans sampled were reviewed by the MDT six-monthly or earlier due to health changes. Other health

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		professionals are involved as appropriate. Short-term care plans sampled were reviewed as required and are resolved, or if an ongoing problem, added to the long-term care plan. Care plans sampled had been updated as residents needs changed. There is at least a three-monthly review by the medical practitioner of the resident and their medications. 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 good communication with the GPs, mental health for the older person's team and the psychogeriatric services. Family/whānau/EPOA are involved as appropriate when referral to another service occurs. Referrals sighted in the resident files sampled include community psychiatric nurse, psychiatry services, geriatrician, wound nurse specialist, DHB specialists and clinics, physiotherapist, dietitian and podiatrist.
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	The service has in place policies 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 sighted were labelled correctly and stored safely throughout the facility. Staff were observed wearing protective equipment and clothing, carrying out their duties. The chemical supplier provides safety datasheets, product use information and conducts quality control checks on the effectiveness of chemicals. Approved containers are used for the safe disposal of sharps. Staff interviewed were able to describe waste management and chemical safety procedures. Partial provisional: The sluice is located in the PG unit and staff working in the dual-purpose unit will need to go into the secure unit to access the sluice (when needed). Procedures are in place around managing this.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and	PA Low	Millvale House has a current building warrant of fitness that expires on 16 May 2018. The facility is divided into two "homes". One which is currently certified for hospital level care and is empty for refurbishment. The psychogeriatric unit has 18 single rooms. There is secure access to the entrance of the psychogeriatric unit. There is a secure nurse's station in the PG unit and a separate nurses station at the entrance of the hospital unit. The two 'homes' are spacious with wide corridors that allow for the use of mobility equipment.

facilities that are fit for their purpose.		Handrails are in place within the communal areas. Maintenance is managed through the DCNZ head office. Maintenance requests are logged into a maintenance book kept in the nurse's station. Minor maintenance requests and repairs are addressed and signed off. External contractors carry out larger repairs and they are available 24/7 for essential services. Electrical equipment has been tested and tagged and clinical equipment has been serviced/calibrated annually. There is a monthly planned maintenance schedule that includes resident mobility equipment. The psychogeriatric "home" has exit and entry access from several doors within the unit. Each of the two 'homes' have a separate outdoor deck and landscaped garden area with safe access. There is seating and shade provided over the summer months. They include a number of paths and raised gardens for residents to access. Each "home" has a high wooden fence around the perimeter of the outdoor area providing security and privacy. The garden areas have established trees and seating areas. Shaded areas are available and there are automated awnings over the lounge windows. Partial provisional: The current closed hospital unit of 13-beds has been refurbished and is to be used as dual-purpose. However, the service is intending to utilise this as mainly rest home level with hospital beds as needed. Each room in the proposed rest home wing is suitable for rest home (or hospital) level residents. All rooms have a basin. Equipment including electric beds are available for the dual-purpose unit. There is a large deck with ramp access extending from the rest home (dual-purpose) lounge into a garden area. Outdoor landscaping of this area is still in process of being completed. The service is also increasing the psychogeriatric level service from 16 to 18 beds. Two rooms that have been used for other purposes, are being converted back into bedrooms (these rooms were previously certified). The service has moved the secure entrance door to opposite the nurses' station. This door also has a secure keypad.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities.	FA	All bedrooms are single in both units and have hand basins. There are adequate numbers of showers and toilets in each unit. 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 privacy curtains. There are appropriately placed handrails in the bathrooms and toilets. Partial provisional:

Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		All individual rooms in the proposed dual-purpose unit are satisfactory to meet the needs of both rest home and hospital level residents.
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 of mobility aids and hoist if necessary. The bedrooms are personalised. The bedrooms environment is uncluttered. There is a mix of bedrooms with carpet and lino flooring. Electric beds or ultra-low beds are available for use. Partial provisional: The large refurbished rooms in the proposed dual-purpose unit are adequate for hospital and rest home level occupancy.
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.	PA Low	The PG unit and the hospital unit have a combined dining/lounge area. There is another smaller lounge in each unit that is readily accessible to residents. Activities take place in the combined dining/ lounge area of the psychogeriatric unit dependent on the type of activity. Both lounges have access to outdoor areas. Seating and space is arranged to allow both individual and group activities to occur. There is adequate space in each 'home' to allow maximum freedom of movement while promoting safety for those that wander. Partial provisional: The proposed dual-purpose wing has a small lounge area at the end of the wing, with a main lounge and attached dining room area at the other end near the entrance and office. There are three areas within the main lounge/dining area yet to be furnished that will provide adequate room for 12 residents should the area become completely full.
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 laundry is situated in the hospital unit (also close to the entrance of the PG unit). Caregivers carry out the laundry and cleaning duties in-keeping with the small homes model and staffing is calculated to ensure sufficient hours for these tasks. Caregivers described how staffing is managed when they leave the PG unit to attend to laundry. All linen and personal clothing is laundered on-site. The laundry area is well equipped with a defined clean/dirty area. There was adequate linen stock sighted (including new linen). Chemicals

appropriate to the setting in which the service is being provided.		are stored safely in the laundry and cleaning area. Safety datasheets are available. Feedback on the service is received through internal audits, meetings and surveys. The chemical supplier completes regular audits on the laundry and cleaning practices, efficiency of equipment and effectiveness of chemical use. Families interviewed were satisfied with the cleanliness of the facility and the care taken with personal clothing. Partial provisional: The laundry is situated in the hospital unit. With the increase in services, a laundry/housekeeping person is being employed (link 1.2.7.3).
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. 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. 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. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. 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. Residents were observed to have their call bells in close proximity. Partial provisional: The emergency management systems in place are satisfactory to meet the needs of the dual-purpose residents. No structural changes have been made to the facility and therefore the fire evacuation plan does not need to be amended. .
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	FA	General living areas and all resident rooms are appropriately heated and ventilated with panel heaters. All rooms have external windows that open allowing plenty of natural sunlight. The wall panel heaters in the psychogeriatric unit have metal protective covers. Bedroom windows open safely. Family members interviewed state the home environment is comfortable. Residents have access to natural light in their rooms and there is adequate external light in communal areas. Partial provisional:

comfortable temperature.		All communal areas and rooms in Millvale House are fitted with individual thermostatically controlled wall mounted heaters.
Standard 3.1: Infection control management 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.	FA	The Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection programme is reviewed annually at an organisational level. Annual goals for 2017 are in place and reviewed at each IC meeting at Millvale. The IC programme plan and programme description are available. There is a job description for the IC nurse and clearly defined guidelines and responsibilities for the Infection Control Committee at service and organisational level. The IC Committee meets monthly and at an organisational level six-monthly. The facility has access to professional advice within the organisation, from GPs and from an IC consultant. Hand hygiene notices are in use around the facility. There is a staff health policy and staff infection and work restriction guidelines.
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 IC as an agenda item. The IC Committee is made up of a cross section of staff from across the service. The service also has access to IC consultant, Pubic Health, GPs and local community laboratory infection control team. The IC coordinator reviews support from the organisation staff trainer, and has completed external training.
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	FA	There is an infection control manual which includes policies and procedures appropriate for the size and complexity of the service. There are policies and procedures that include, but are not limited to: a) infection control nurse responsibilities; b) antimicrobial usage; c) infection control including renovations and construction; d) accidental exposure to blood; e) healthcare waste; f) definitions of infections; g) outbreak management. Any changes or updates to the infection control policies are notified at the staff meetings.

implemented in 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 coordinator is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control hand hygiene competency. The IC coordinator (facility manager/RN) has completed external training. Staff receive infection control training on orientation and annual infection prevention and control 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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. 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 coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which are congruent with the definitions in NZS 81340. Interviews with the caregivers and nursing staff confirmed their understanding of restraints and enablers. At the time of the audit, there were no residents utilising enablers and seven residents assessed for using restraints in the form of H belts. A register is maintained by the restraint coordinator/RN. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours. Suitably qualified and skilled staff in partnership with the family/whanau, undertakes these. The RN/restraint coordinator (FM) is involved in the assessment process along with the family and GP.

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 (FM) is a registered nurse and 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". Consent for restraint use is logged in the restraint register. Assessments are undertaken by suitably qualified and skilled staff such as the RN and GP, in partnership with the resident (where able) and their family/whānau. The multidisciplinary team is involved in the assessment process.
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 comprehensive assessments for residents who require appropriate restraint or enabler intervention. Suitably qualified and skilled staff in partnership with the family/whānau undertakes these. A restraint risk assessment, consent and management form is completed and signed by the resident representative (family/EPOA), RN and GP and this was documented in the three restraint resident files reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint policy requires that restraint be 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 or for hand holding in the progress notes. The assessment for restraint includes exploring alternatives, risks, other needs and behaviours. Three files were reviewed for residents with intermittent restraint. The risk assessment, consent and management form addresses criterion 2.2.3.2 and the restraint intervention is fully described in the care plan with daily monitoring records completed by staff. Most residents with a H belt approved have this approved for up to two hours at any one time. However, one resident has a H belt restraint approved for a maximum of 30 minutes at a time. The restraint register is in place and shows monthly evaluation. An updated register is completed each month and shows discontinued restraints.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The files reviewed of residents requiring restraint have been evaluated at least three-monthly. Family/whānau participate in evaluations and at the residents' multidisciplinary review. Use of restraint is discussed at monthly registered staff meetings. The restraint evaluation includes the areas identified in

		2.2.4.1 a) – k). A restraint evaluation is completed of the restraint care plan monthly.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The files reviewed of residents requiring restraint have been evaluated at least three-monthly. Family/whānau participate in evaluations and at the residents' multidisciplinary review. Use of restraint is discussed at monthly registered staff meetings. The restraint evaluation includes the areas identified in 2.2.4.1 a) – k). A restraint evaluation is completed of the restraint care plan three-monthly. Evaluation timeframes are determined by risk levels.

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 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	A transition plan has been established that includes the draft roster for the dual-purpose unit. Advised that the current organisational recruitment processes will apply, managed locally by the facility manager and operations coordinator, supported by the operations management leader as required. The service is in the process of advertising for new staff (experienced in aged care) for the unit.	Partial Provisional: Not all staff (caregivers/RNs/DT) have been employed to cover the dual-purpose unit.	Ensure there are sufficient staff in place to cover the dual-purpose unit. Ensure there are 24/7 RN’s employed where hospital residents are admitted to the dual-purpose unit. Prior to occupancy days
Criterion 1.4.2.6 Consumers are provided with safe and accessible	PA Low	The psychogeriatric unit “home” has exit and entry access from several doors within the unit. Each of the two units have a separate outdoor deck and landscaped garden area with safe access. There is seating and shade provided over the summer months. The outdoor areas	Partial Provisional: There is a large deck with ramp access extending from the rest home (dual-purpose) lounge into a garden area. Outdoor	Ensure outdoor area off the dual-purpose home is fully completed.

external areas that meet their needs.		include a number of paths and raised gardens for residents to access. Each “home” has a high wooden fence around the perimeter of the outdoor area providing security and privacy. The garden areas have established trees and seating areas. Shaded areas are available and there are automated awnings over the lounge windows.	landscaping of this area has been upgraded and is still in the process of being completed.	Prior to occupancy days
Criterion 1.4.5.1 Adequate access is provided where appropriate to lounge, playroom, visitor, and dining facilities to meet the needs of consumers.	PA Low	The PG unit and the hospital unit have a combined dining/lounge area. There is another smaller lounge in each unit that is readily accessible to residents. Activities take place in the combined dining/ lounge area of the psychogeriatric unit dependent and will also occur in the combined lounge/dining area in the dual-purpose unit. There is another smaller lounge area for privacy or individual activities in each unit.	Partial provisional: The position of furniture will need to be considered in the main lounge/dining room in the dual-purpose unit.	Partial provisional: Ensure the position of furniture is reviewed to meet the needs of both rest home and hospital level residents Prior to occupancy days

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 House Levin has a business plan, quality plan, health and safety plan and infection control plan. A quality monitoring programme is implemented and this 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 improvement (QI) projects running and all staff and families are encouraged and	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. Example: DCNZ has a national goal around PI prevention. Millvale House Levin implemented the national goal and introduced strategies to identify at risk residents and major challenges. Each new incident is reviewed and preventative measures including (but not limited to): focus on nutrition, activities, pressure relieving devices are instigated immediately and analysed for effectiveness. Increase in staff training and awareness.

		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.	Evaluation identified that there has been a reduction in the number of pressure injuries in 2017 (YTD) with an 0.2 average compared to 2016 of 1.92 average.
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	Benchmarking reports are generated throughout the year and an annual review of the data is completed. A quality improvement register is utilised at Millvale and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. All meetings include feedback on quality data where opportunities for improvement are identified. There is a strong quality link and oversight by DCNZ head office.	The service is active in analysing data collected monthly, around accidents and incidents, infection control, restraint etc. As a result of quality data collected, the facility manager and DCNZ quality systems manager feeds back monthly to staff through the monthly operations quality bulletin, issues arising and identified trends or issues. Any identified common themes around incidents/infections etc. results in further education and updates at handovers between shifts and meetings. Documentation reviewed identified that strategies are regularly evaluated. One goal Millvale focused on was to reduce all incidence of medication errors by identifying major challenges. Once the key challenges/trends were identified, strategies were implemented including (but not limited to) increased training and oversight and review of effectiveness of PRN medication. Evaluation identified that 2016 data evidenced that there had been a 12-month average of 1.49 errors. In 2017, data evidenced 0 errors (YTD).

End of the report.