

# Millvale House Miramar Limited - Millvale House Miramar

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## 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:

<b>Legal entity:</b>	Millvale House Miramar Limited
<b>Premises audited:</b>	Millvale House Miramar
<b>Services audited:</b>	Hospital services - Psychogeriatric services; Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 21 August 2019 End date: 22 August 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	22

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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 Miramar. The service provides hospital (psychogeriatric) level care for up to 26 residents and rest home level care. On the day of audit, there were 22 residents.

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

An operations coordinator and a clinical manager manage Millvale House Miramar and are on site Monday to Friday. The operations coordinator has been in the role for the last four months and the clinical manager (experienced registered nurse) was appointed four weeks ago. There is a supportive governance team who were present during the audit.

Families interviewed during the audit were very satisfied with the quality of the care provided at Millvale Miramar.

There were no areas identified for improvement at this certification audit.

The service has achieved a continuous improvement rating around reduction of urinary tract infections.

## Consumer rights

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisational quality and risk management plan includes goals and objectives that are regularly reviewed and discussed in facility meetings. Progress with the quality and risk management plan is monitored through the quality meeting. The operations coordinator and clinical manager collate and monitor all quality data. There is a benchmarking programme in place across the organisation. The internal audit schedule is being completed. Areas of non-compliance identified at audits have had corrective action plans developed and signed off as completed. Relative surveys are undertaken annually. Incidents and accidents are appropriately managed. Appropriate staff are recruited and provided with a comprehensive orientation. An annual education plan

has been implemented and staff have received appropriate training including dementia-specific training. There are sufficient staff on duty, including a registered nurse at all times, to meet the needs of the residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is a well-presented information booklet for residents/families at entry that includes information on the service philosophy, services provided and practices particular to the secure unit. Assessment and care plans are developed by registered nurses and reviewed six monthly by the multidisciplinary team. Families are involved in the development and review of the care plan. A multi-disciplinary team review occurs three monthly. InterRAI assessments are linked into the comprehensive care plan. A 24-hour multidisciplinary care plan identifies a resident's behaviours and activities or diversions that are successful. There is at least a three-monthly resident review by the medical practitioner and psychogeriatric community clinical nurse specialist as required. The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident.

Individual activity plans are developed in consultation with resident/family.

The medication management system meets legislative requirements. Registered nurses are responsible for the administration of medications. Education and medication competencies are completed annually. All medication charts have current identification photos and document the resident allergy status. The GP reviews the resident's medication at least three monthly.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. There is a current building warrant of fitness. Emergency and disaster plans in place guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan and fire drills occur six monthly. Residents were able to move freely inside and within the secure outside environments. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. General living areas and resident rooms are appropriately heated and ventilated. There is staff on duty with a current first aid certificate. There is a civil defence plan in place that is known to staff. The service has policies and procedures for effective management of laundry and cleaning practices.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint policies and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. The service had no residents using enablers and six residents using restraints. A register is maintained by the restraint coordinator/clinical manager. Residents using restraints are reviewed monthly at RN meetings, three-monthly by the GP and evaluated six monthly by the restraint 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.

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

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 registered nurse is responsible for coordinating/providing education and training for staff. The clinical manager and infection control team support the infection control registered nurse. Infection control training is provided on orientation and ongoing. 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 registered nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. 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	49	0	0	0	0	0
Criteria	1	100	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	There is a code of rights policy and procedures in place. The code of health and disability rights is incorporated into care. Discussions with four caregivers identified their familiarity with the code of rights. A review of care plans, meetings and discussion with one rest home resident and five family members (of psychogeriatric residents) confirmed the service functions in a way that complies with the code of rights. Observation during the audit confirmed this is in practice. Code of rights training is included in the staff orientation and in the education planner.
Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	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. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents advance directive where applicable, are on file. All resident files reviewed (one rest home and four psychogeriatric including one resident under the Mental Health Act and one ACC resident) had copies of the EPOA (enacted for the psychogeriatric residents) or welfare guardian on file. Interviews with staff and families stated they have input and are given choices. Care plans and 24 hours multidisciplinary care plans demonstrated resident choice as appropriate.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>The right to access advocacy services is identified for residents/families and brochures are available at the front entrance. The information identifies whom to contact to access advocacy services. Information provided to families prior to entry to the service provides them and family/whānau with advocacy information. Staff are aware of the right for advocacy and how to access and provide advocacy information to relatives/residents if needed and training has been provided. Local support groups offer advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has open visiting hours. Family are actively encouraged to visit, as observed on the day of audit. Relatives interviewed stated they could visit at any time. Community entertainers and church services are brought into the facility. The rest home resident is supported to maintain community involvement.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. There are concerns/complaint forms and information available at the entrance. Information about the complaints process is provided on admission. Staff interviewed could describe the process around reporting complaints. An established on-line complaints register includes date of complaint, acknowledgment date, investigation, outcome and complainant response/resolution.</p> <p>Three internal complaints made in 2018 were reviewed. The complaints lodged were documented as resolved. There were no complaints for 2019 to date.</p> <p>There was one HDC complaint March 2018 which was investigated, unsubstantiated and closed off.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Code of rights posters are displayed at the front entrance of the facility. The information pack for new residents/families on entry includes information about the code of rights, complaints procedure and services provided. Resident and families right to access advocacy services is identified and advocacy service leaflets are also available at the front entrances. On entry to the service, the operations coordinator or clinical manager discusses the information pack with the resident (as appropriate) and their family/whānau. Discussions with the caregivers and registered nurses identified they are aware of the right for advocacy and</p>

		how to access and provide advocacy information to residents if needed.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and ongoing assessment includes gaining details of resident's beliefs and values. Interventions to support these are identified in the care plans and evaluated to ensure the residents needs are being met. Care staff interviewed (four caregivers, two registered nurses and one diversional therapist) could describe how confidentiality was maintained. Staff sign a confidentiality clause contained within the employment agreement on employment.</p> <p>The service's philosophy focuses on residents' right to respect, privacy and safety and have adopted the "best friends" approach to resident care. There is a policy that covers abuse and neglect and staff have completed abuse and neglect training. During the visit, staff demonstrated knocking on doors prior to entering resident private areas. Interviews with family members identified that caregivers are always respectful and caring.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are policies and procedures for the provision of culturally safe care for Māori residents. On the day of the audit there were two residents who identified as Maori. There is an established Māori health plan and there is an external Māori cultural advisor who is available to provide assistance and guidance for Māori residents. Cultural needs are documented in the care plan as sighted on review of the two Māori resident files reviewed. Family/whānau involvement is encouraged in assessment and care planning. There are current guidelines for the provision of culturally safe care for Māori residents. Bi-cultural awareness training occurs as part of the annual in-service education, last completed July 2019.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values,</p>	FA	<p>The staff focus on the residents' right to be accepted as an individual and being given the opportunity to enhance the values and beliefs in their lives. Each resident has an individualised care plan which reflects their values including cultural and spiritual beliefs. There is evidence the family/whānau is involved in the development of the care plan. Family members interviewed stated they are involved in care plans and supports required to ensure the residents individual needs are met.</p>

and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. Complaints regarding any alleged harassment, coercion, discrimination or abuse of any kind by a staff member are fully investigated and may be dealt with via both the complaint management and disciplinary processes. Discussions with the operations coordinator and a review of complaints identified no complaints of this nature.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>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/relatives' meetings, surveys, quality meetings, health and safety meetings, staff appraisals, satisfaction audits, education and competencies, complaints and incident management. The education programme includes "Best Friends Approach to Dementia Care" (putting yourself in their shoes) training that is carried out for all staff regularly and this is key to living their values and philosophy. There are long-serving care staff who know the resident's individual needs well. Staff are supported by a workplace wellbeing programme and free counselling service. A counsellor also visits the site weekly and is available for staff and families if required. There is staff debriefing following incidents of challenging behaviours with good management and team support. In-service education sessions include input from external specialists and clinical policies and procedures are updated to reflect good practice. Monthly quality bulletins are published for staff and include information such as quality data results, infection control surveillance, and education opportunities.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is an open disclosure policy in place. A site-specific introduction to the psychogeriatric unit booklet provides information for family, friends and visitors to the facility. A family newsletter "our home" is published and distributed to family and is available at the main entrance. Families are informed on service updates including the outcomes of surveys. Family have a direct dial number to discuss any concerns with the national clinical manager. Information is readily available on local support groups meetings and activities such as the dementia Wellington group and men's group.</p> <p>Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Sixteen incident/accident forms were reviewed from June 2019. All 16 incident/accident forms evidenced family had been informed. Relatives interviewed, confirmed they are notified of any changes in their family member's health status. The family members interviewed spoke very positively about the care provided and were well informed and felt supported.</p>

<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Dementia Care NZ Limited (DCNZ) is the parent company under which Millvale House Miramar operates. Millvale House Miramar provides psychogeriatric level care and rest home level care for up to 26 residents with 21 residents receiving psychogeriatric level care in the home on the day of audit, and one rest home level care resident. This included one resident on a mental health (independent) contract and one resident on an ACC funded contract, both receiving psychogeriatric level care. All other residents were on the aged residential related care (ARHSS) contract.</p> <p>DCNZ has an overarching two yearly business plan that is developed in consultation with managers and reviewed regularly. Millvale Miramar has a quality plan, health and safety plan and infection control plan which are all reviewed by relevant staff six monthly. Clinical goals such as falls reduction has continued in the 2019 quality plan. The service achieved a reduction in UTIs (link CI 3.5.7).</p> <p>DCNZ has a corporate structure that includes the two managing directors and a governance team of managers including a clinical advisor, national clinical manager, quality systems manager and national education coordinator who were present during the audit. The site operations coordinator (non-clinical) has been in the role four months and reports to the operations management leader at head office. A clinical manager was appointed four weeks ago and is currently completing role-specific orientation. He is an experienced registered nurse who previously worked at Millvale Miramar as an RN before leaving to gain further experience as a clinical manager in psychogeriatric level of care. The MOH was notified of the clinical managers appointment.</p> <p>The organisation holds an annual training day for all operations and clinical managers which is scheduled for 10 September 2019. The operations coordinator completed role-specific orientation on employment. Both managers have been supported by the organisational team who visit the site regularly.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence of the operations coordinator, the clinical manager assumes the role with support from the DCNZ management team. In the absence of the clinical manager, a senior RN will cover the role with support from the DCNZ clinical management support team.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is a current quality risk management plan. Progress with the quality and risk management programme is monitored through the quality meetings and the senior management team meetings weekly. The operations coordinator and clinical manager log and monitor all quality data and report any actions required to achieve compliance where relevant. Quality data is reported through a number of facility meetings including quality meetings, infection control, health and safety, registered nurse meetings and restraint meetings. Meeting minutes sighted included quality improvement reports and evidenced discussion around quality data including accidents, incidents, infection control, restraint use, pressure injuries, concerns/complaints and internal audit outcomes. Discussions with staff confirmed their involvement in the quality programme. Benchmarking with other facilities occurs on data collected.</p> <p>The internal audit schedule for 2018 has been completed and 2019 is being completed. The operations coordinator completes non-clinical audits and the clinical manager completes clinical audits or delegates to the relevant team/committee. Areas of non-compliance identified at audits (less than 100%) have corrective action plans developed and signed as completed (documented in meeting minutes). Re-audits are completed as required. The DCNZ quality systems manager reviews and monitors all events and audit results.</p> <p>Welfare guardian surveys are completed annually, however due to the poor response rate for January 2019 the contact list was updated, and the survey has been re-sent and in progress.</p> <p>The service has comprehensive policies and procedures to support service delivery. The policy and document development and review group at head office review policies in consultation with relevant staff and distribute to the facilities. Staff are informed of any new/reviewed policies.</p> <p>The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. A senior caregiver is the health and safety representative who has completed the health and safety course - level one. The health and safety committee are representative of areas across the service and meet monthly. Meetings minutes are available for staff. Staff have the opportunity to raise any health and safety concerns/suggestions. There is a current hazard register and hazard report forms in the staff room. Contractors receive induction to the service and are accompanied to their work area.</p> <p>Falls prevention strategies are in place that includes assessment of risk, medication review, sensor mats, wearing of hip protectors, assessments with physiotherapy input, exercises/physical activities, training for staff on prevention of falls 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.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	FA	<p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Sixteen</p>

<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>incident/accident forms reviewed, identified they were fully completed and followed-up appropriately by the RN. Minutes of the monthly quality meeting, health &amp; safety meetings and RN/clinical meetings reflected a discussion of incidents/accidents and actions taken. Neurological observations are completed (as far as practical) for unwitnessed falls or obvious knock to the head.</p> <p>Discussions with the operations coordinator and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been four section 31 notifications completed since the last audit. Notifications were two residents absconding (one resident absconded twice) in October and November 2018. There was one gastrointestinal outbreak in May 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Six staff files were reviewed (one clinical manager, one registered nurse, two caregivers, one diversional therapist and one cook). Job descriptions, reference checks and employment contracts were evident in all files reviewed. Performance appraisals were up to date. A copy of practising certificates was sighted for all registered nurses and allied/medical staff.</p> <p>The service has in place a comprehensive orientation programme that provides new staff with role-specific information for safe work practice. The DCNZ educator is in the process of revising orientation and competency packs. Care staff interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service. All six files reviewed showed evidence of orientation to roles with competency packages completed. The clinical manager is currently completing orientation under the supervision of the national clinical manager.</p> <p>Competency packages are completed, relevant to the role including medication administration, safe manual handling, restraint minimisation and safe practice, safe food handling, infection control, advocacy and abuse and neglect.</p> <p>The annual training programme for 2018 has been completed and the 2019 education schedule is being implemented with monthly education sessions that covers all required topics. Registered nurses attend DCNZ education days and are also linked to the DHB professional development recognition programme with opportunities to attend DHB study days. The educator provides “zoom” sessions and an office area has been set up where staff can access the “zoom” sessions. External speakers/presenters are included in the training schedule such as pharmacist, physiotherapist and hospice nurses. The educator provides regular staff training on the ‘best friends’ model of care, challenging behaviours and mental health.</p> <p>The educator is a Careerforce assessor and supports caregivers to complete the aged care education certificate core and dementia standards. There are 12 caregivers, 11 have completed the required dementia standards and one caregiver employed in July 2019 with level three is registered to commence dementia unit standards. There is one qualified DT and one in training.</p>

		There are four registered nurses and two have completed interRAI training (including the clinical manager).
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a registered nurse on duty in the home 24/7. Sufficient staff are rostered on to manage the care requirements of the residents. The operations coordinator and the clinical manager work fulltime Monday to Friday. The clinical manager is on-call and is rostered an RN clinical day as required.</p> <p>Staffing is as follows:</p> <p>Loloma unit – 13 beds</p> <p>Kabigan unit – 13 beds</p> <p>One RN 24/7.</p> <p>Morning shift: two caregivers full shift (7am – 3pm), one caregiver short shift until 1pm and one caregiver from 1pm to 6.30pm (funded by DHB for one on one time for one resident).</p> <p>Afternoon shift: two caregivers from 3 pm to midnight</p> <p>Night shift: one home assistant (midnight to 8 am).</p> <p>There is one caregiver allocated to the care of the rest home resident.</p> <p>There is one home assistant on the morning shift 8am to 12.20pm and one on the afternoon form 4.45pm to 7.15pm. Home assistants complete serving of meals etc, laundry and cleaning duties. Activities staff: one x 10.30 am to 5.30 pm, one x 1.30 pm to 5.30 pm x five days. The DT goes with the driver and volunteer on van outings. Interviews with staff and the one family member identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurse's station. Resident records are kept up to date and reflected residents' current overall health and care status. Active archives are appropriately sorted and are accessible as required. Other records are stored in a locked and dry shed on site and periodically moved to another safe location at another DCNZ site.</p> <p>Entries were legible, dated and signed by the relevant staff member including designation. Residents files were integrated. Medication charts were kept separately.</p>



<p><b>Standard 1.3.1: Entry To Services</b></p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are pre-entry and admission procedures in place. Residents are assessed prior to entry by the psychogeriatric team and needs assessment coordinators. The clinical manager liaises closely with the assessing teams to ensure the service can meet the assessed resident needs and directly contacts the service they may be transferred from to do a pre-assessment.</p> <p>The service has a well-presented information booklet for residents/families at entry. It is comprehensive and designed so it can be read with ease (spaced and larger print). Five family (of psychogeriatric residents) stated they received sufficient information on the services provided and are appreciative of the staff support during the admission process.</p> <p>Admission agreements reviewed in five files (one rest home and four psychogeriatric) aligned with the ARC and ARHSS contract. Admission agreements had been signed within a timely manner.</p>
<p><b>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</b></p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a discharge planning and transfer policy 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 staff member or family member (as appropriate) accompanies the resident to the hospital.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management system includes policy and procedures that follows recognised standards and guidelines for safe medicine management practice. An electronic system is used. The RN on duty checks medications on delivery against the medication charts. RNs administer medications and they have completed annual medication competencies and education.</p> <p>Caregivers complete education and demonstrated competency for checking medication. There were no self-medicating residents. There are no standing orders. All medications were stored safely. The medication fridge temperature is monitored.</p> <p>All 10 medication charts reviewed had photo identification and allergies noted. There were no gaps in the administration signing sheets. 'As required' medications had prescribed indications for use. The effectiveness of PRN medications was recorded on the electronic system and in the residents' progress notes. The 10 medication charts had been reviewed by the GP three monthly.</p>
<p><b>Standard 1.3.13: Nutrition,</b></p>	FA	<p>There is a food control plan in the kitchen, which covers all aspects of food preparation, kitchen management,</p>

<p>Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>food safety, kitchen cleaning and kitchen procedures. There is one fulltime cook who does 40 hours over four days and one part time cook who works 30 hours Friday to Sunday. Both cooks hold relevant NZQA units and attend chemical safety, first aid and relevant in-service training. A home assistant undertakes the cleaning of the kitchen (schedule in place). The kitchen is located within the psychogeriatric home and is locked via a combination lock so that only staff can access this area. There is a kitchenette in the dining areas where food is dished up to residents. Containers of food are transported in hot boxes to the kitchenette, where caregivers plate and serve the meals.</p> <p>There is a summer/winter rotating menu which was reviewed by the dietitian June 2019. The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Pureed and normal diets are provided. Resident likes and dislikes are known, and alternative foods are offered. Cultural and spiritual needs are met. There were adequate fluids sighted in the kitchenette fridges and supplement protein drinks were available. There is daily monitoring of hot food temperatures, fridge and freezer temperatures, dishwasher rinse temperatures and delivery temperatures for chilled/frozen goods. All perishable foods in the kitchen fridges and freezer were dated. The dry good store had all goods sealed and labelled. Goods are rotated with the delivery of food items. The cook was observed wearing appropriate personal protective clothing. Chemicals were stored safely within the kitchen. There were safety data sheets available. Weights are monitored monthly or more frequently if required. Residents assessed by the dietitian who require supplements received these and this was recorded in the resident's file.</p> <p>The latest food control plan has been approved for eighteen months (May 2020). Residents and relatives expressed a high level of satisfaction with the meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to potential residents is recorded should this occur and communicated to the potential resident (as appropriate)/family. The clinical manager reported that the referring agency would be advised when a potential resident is declined access to the service, and it would usually be if there were no vacancies or the potential resident was not assessed for the levels of care offered.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and</p>	FA	<p>The information gathered at admission is used to develop care needs and supports to provide best care for the residents. Registered nurses' complete initial assessments within 24 hours of admission including risk assessment tools. Risk assessment tools are reviewed at least six monthly. InterRAI assessments have been completed six monthly. The outcomes of interRAI assessments including the risk assessments, were reflected</p>

preferences are gathered and recorded in a timely manner.		<p>in the long-term care plans reviewed. The diversional therapist completes a comprehensive social assessment in consultation with the resident/family, along with the 24-hour plan of activity for the psychogeriatric residents.</p> <p>Four psychogeriatric resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The long-term care plan is developed within three weeks of admission. The care plans are comprehensive and document interventions to meet the resident's needs. The outcomes of interRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs. Care plans demonstrated allied health input into the residents' care and well-being. InterRAI assessment notes provided evidence of family involvement in the assessment and care planning process. Five family members confirmed they are involved in the care planning process.</p> <p>One rest home and four psychogeriatric resident files (including one resident under the Mental Health Act and one ACC funded) reviewed, identified current abilities, level of independence, identified needs and specific behavioural management strategies.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The care being provided is consistent with the needs of residents as demonstrated in the review of the care plans and discussion with caregivers, registered nurses, diversional therapist and management. Families interviewed stated their relatives' needs are being met. When a resident's condition changes, the RN initiates a GP or nurse specialist consultation. Families confirmed they are notified promptly of any changes to health status.</p> <p>Wound assessments and evaluations have been completed for the one wound (chronic). The wound nurse and GP have been involved in the wound care and management of the wound. There was one facility acquired stage one pressure injury identified the day prior to audit. A short-term care plan including the use of an air alternating mattress when in bed, change of position two hourly (a monitoring chart was in place to record same), and a dietary supplement. The family member (interviewed) had been notified of the injury. Specialist wound and continence management advice is available as needed and this could be described by the clinical manager and RNs interviewed.</p> <p>Continence assessments including a urinary and bowel continence assessment are completed on admission and reviewed six monthly. The company has a resource person.</p> <p>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. The effectiveness of pain medication is recorded on the Medimap medication system.</p>

		<p>The dietitian visits regularly, completes any resident reviews due, and attends to any referrals received. The dietitian maintained progress notes in the integrated resident file.</p> <p>Challenging behaviour assessments were well documented with amendments made to the care plan as required.</p> <p>There is good specialist input into the resident's care in the psychogeriatric unit. The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment. The Wellington community mental health team are available and the psychogeriatric community nurse visits regularly and liaises closely with the psychogeriatric team.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The diversional therapist (a qualified DT) has been in the role two and a half years. The DT is employed Monday to Friday 6.5 hours daily. On Saturday and Sunday, a DT in training works 10.30 am to 5.30 pm. 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.</p> <p>The programme for the psychogeriatric residents is focused on individual (the DT had learnt Māori songs to sing with a resident who identifies as Māori) and small group activities that are meaningful including household tasks, reminiscing and sensory activities such as massage and foot spas, baking, garden walks, games music and movies. The rest home resident joins in as desired and also has alternative activities.</p> <p>There are volunteers involved in the programme with spiritual services, pet therapy twice weekly, weekly piano playing, singers performing weekly and another group monthly. Recreational doll therapy was observed being successfully used. There is a visiting priest weekly and on request. The priest also visits to read to the blind resident. Care staff also assist with pamper sessions. The service has a wheelchair van which is used to take residents out weekly. The DT has a current first aid certificate.</p> <p>Activity assessments, activity plan, 24-hour MDT care plan, progress notes and attendance charts are maintained. Resident and family meetings are held.</p> <p>A comprehensive social history is completed on or soon after admission and information gathered from the relative (and resident as able) is included in the activity care plan. A 24-hour MDT care plan is reviewed at least six monthly.</p> <p>Caregivers were observed at various times throughout the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions. Activities were observed to be occurring in the three lounges simultaneously. Families expressed very positive comments and satisfaction with the activities programme.</p>
Standard 1.3.8: Evaluation	FA	Initial care plans were evaluated by the RN within three weeks of admission in the files reviewed. Nursing care

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		plans are reviewed six monthly by the multidisciplinary team (MDT) and evaluated at least six monthly or earlier due to health changes. The family 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 reviewed as required and resolved, or if an ongoing problem, added to the long-term care plan. There is at least a three-monthly review by the medical practitioner 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. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the need's assessment and psychogeriatric teams.
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, management of waste and hazardous materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. These include (but are not limited to): a) sharps procedure, b) cleaning/chemicals procedures and c) exposure to blood or other body fluid contamination policy. Training is provided to the staff around safe management, as part of the annual training plan. Chemicals were labelled and there was appropriate protective equipment and clothing for staff.
Standard 1.4.2: Facility Specifications  Consumers are provided	FA	The service is overseen by the managing director who oversee the site and arrange for preventative maintenance to ensure that buildings, plant and equipment are maintained appropriately. Requests can be generated by the facility and there is also a reactive maintenance request book. A handyman is employed for 12 hours per month and the on-site operations coordinator organises and undertakes some aspects of

with an appropriate, accessible physical environment and facilities that are fit for their purpose.		<p>maintenance, (eg, temperature recording). The facility displays a current building warrant of fitness which expires 29 June 2020. Fire drills are conducted six monthly and the fire service has approved the evacuation scheme. Electrical equipment has been tested and tagged. Contractors are available 24/7 for essential services. Hot water temperatures are monitored weekly and are below 45 degrees Celsius (sighted). Residents were able to move freely inside and within the secure outside environments. There is easy viewing of outside along with easy access (including doors from individual bedrooms). There are sheltered outdoor areas and paths that are maintained for safe walking. Outside areas include seating and shade. The psychogeriatric unit is spacious allowing for the use of mobility equipment with three lounge/dining areas that can all be seen from the central nursing station. The one rest home resident freely accesses and exits the unit as desired.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of toilets and showers with access to a hand basin and paper towels. There are six communal toilets and four communal showers in the psychogeriatric area (maximum of 26 residents) and separate facilities for the rest home resident. Each bedroom has a handbasin. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All residents' rooms are single and of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in communal bathrooms. There was evidence of rooms being personalised.</p>
Standard 1.4.5: Communal Areas For Entertainment,	FA	<p>There are three lounges/dining rooms within the facility, they are well proportioned and can accommodate the lounge furniture and dining tables. Activities can occur in any of these areas. There is adequate space to</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>allow maximum freedom of movement while promoting safety for those that wander.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The service has in place policies and procedures for effective management of laundry and cleaning practices. This included (but is not limited to) collection of soiled laundry, linen processing and transporting. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. There is a sluice room for the disposal of soiled water or waste.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergencies, first aid and CPR were included in the mandatory in-service programme. All RNs have current first aid certificates providing staff on duty 24 hours with first aid certificate. The facility has an approved fire evacuation plan and fire drills occur six monthly. Emergency lighting and cooking is available in the event of a power failure. There is battery back-up for the call bell system. A generator is hired as required. There are civil defence kits (checked monthly) that are readily accessible and stored water. Call bells are evident in residents' rooms, lounge areas and toilets/bathrooms. The facility is secured at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>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 by skype meeting with other infection control coordinators and the national clinical manager.</p> <p>There is a job description for the IC nurse (clinical manager) and clearly defined guidelines and responsibilities for the infection control committee. The infection control committee include the operations coordinator, RNs, DT, laundry person and cleaner. The infection control committee meet monthly and minutes are posted on the staff noticeboard.</p> <p>An established and implemented infection control programme is linked into the objectives of the quality and risk management plan. The IC programme includes objectives around reducing infections and education.</p> <p>Visitors are asked not to visit when unwell. There are hand sanitisers placed throughout the facility. Residents and staff are offered the influenza vaccine.</p> <p>There has been one gastrointestinal outbreak in May 2018. The public health unit and MOH were notified. Case logs and the notification was sighted.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IC committee meets monthly and is made up of a cross-section of staff from across the service. The service also has access to IC consultant, Public Health and GPs. There is expertise at head office with the clinical advisor and national clinical manger readily available for advice and support. An independent Microbiologist is readily available for advice and education. The infection control coordinator has completed infection control certificates.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative</p>	FA	<p>There is an infection control manual which includes policies and procedures appropriate to 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. Policies and procedures are reviewed by policy development and review group in consultation with infection control coordinators. Staff are notified of any reviews/updates at the staff meetings.</p>



requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The 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 competency. Staff attend annual infection control education.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	CI	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Infections are collated in a monthly register and a monthly report is completed by the infection control coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is reported at the quality, infection control committee 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 GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities. Millvale Miramar has been successful in reducing urinary tract infections for residents with dementia.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes restraint procedures. The restraint coordinator is a registered nurse. Interviews with caregivers and nursing staff confirmed their understanding of restraints and enablers. There were six residents with restraint (three with H-belt and three with arm restraint). There were no residents using enablers on the day of audit. Staff complete restraint competencies and attend education and training in restraint minimisation and safe practice and challenging behaviours.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Responsibilities and accountabilities for restraint are outlined in the restraint policy and include roles and responsibilities for the restraint coordinator (RN) and approval group. The restraint approval group meets six monthly. There are six monthly skype meetings with the national restraint group. Restraint is discussed at monthly RN meetings and care staff have ongoing education as part of the annual education programme.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments are undertaken by the restraint coordinator/RN in partnership with the GP, resident (as appropriate) and their family. Restraint assessments are based on information in the care plan, family, staff and GP consultation and during observations. The restraint assessment tool is completed for residents requiring an approved restraint for safety. There is provision for emergency restraint if required for safety of the residents, other residents/staff and the family is notified.</p> <p>Ongoing consultation with the family and staff is evident through multidisciplinary meetings and facility meetings. There were six residents with the use of restraint as required (three arm restraints, on and three with H-belts). Three restraint files reviewed (one arm restraint and two H-belts) included completed assessments that considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has a restraint approval process that is described in the restraint minimisation policy. Monitoring and observation is included in the restraint policy. The restraint coordinator is a registered nurse and is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>Restraint authorisation is in consultation/partnership with the family, restraint coordinator and GP. Internal audits are completed to ensure all restraint processes are completed as per the restraint policy and procedures. The restraint coordinator reported that each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form (sighted).</p>

		A restraint register is in place providing an auditable record of restraint use. This has been completed for all residents requiring restraints.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). The use of restraint is reviewed by the GP at the three-monthly resident reviews. Evaluations occur six-monthly as part of the multi-disciplinary review for the resident on restraint. Families are included as part of this review. A review of three files of residents using restraints identified that evaluations were up to date.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraints are discussed and reviewed at the monthly registered nurse meetings. Meeting minutes included a review of the restraint and challenging behaviour education and training programme for staff. Staff receive orientation in restraint use on employment. The DCNZ educator (qualified psychiatric nurse and Careerforce assessor) provides training for staff. There is internal benchmarking.

## Specific results for criterion where corrective actions are required

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	CI	A UTI reduction project action plan was implemented for 2018 to reduce UTIs to zero for the services group of vulnerable residents with advanced dementia. The service has been successful in reducing to zero UTIs for 2018 and none to date for 2019.	The project plan included regular training and education of staff, increased fluids, preventing decline in continence status through regular toileting, appropriate incontinence products for residents resistant to toileting, monitoring of bowel issues and improve reporting of bladder habits and bowel including results from laxatives, attention to hygiene needs, use of yoghurt for residents prone to UTIs and thorough physical assessments for residents with suspected UTI. Interventions were successful and the goal of zero UTIs has been achieved with reduction in discomfort and ongoing complications for residents prone to UTIs. Unwanted behaviours from symptoms of UTI has been reduced. There were no UTIs during the period of gastrointestinal outbreak, confirming good infection control practice and good perineal hygiene, bladder and bowel management.

End of the report.