

Millvale House Levin Limited - Millvale House Levin

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Millvale House Levin Limited

Premises audited: Millvale House Levin

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 2 March 2020 End date: 3 March 2020

Proposed changes to current services (if any): .

Total beds occupied across all premises included in the audit on the first day of the audit: 19

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 is certified to provide psychogeriatric, hospital and rest home level care for up to 30 residents. There were 18 residents in the psychogeriatric unit on the day of audit. The service is currently not accepting hospital level residents and there was one rest home resident at the service on the day of audit in the 12-bed dual-purpose unit.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with family, management, staff and the general practitioner.

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

Two of the three shortfalls at their last audit (partial provisional) in relation to outdoor landscaping and furniture have been addressed. The shortfall around RN staffing for hospital level remains an area for improvement.

An improvement around interventions has been identified at this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information about the Code of Rights and complaints process is readily available to residents and families. A site-specific introduction to the dementia unit booklet provides information for family, friends and visitors to the facility. There is a regular support group for families. Newsletters keep families informed on the service. Family are involved in the resident care plans and evaluations. Complaints processes are implemented, and complaints and concerns are actively managed and well documented. A complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Dementia Care NZ has an established clinical governance group. The service has a well-established quality and risk management system. The quality system includes surveys, internal audits, meetings and analyses of quality data. 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 specific training

around “Best Friends Approach to Dementia Care” and specific behaviour management training. The service provides staff with a confidential counselling service.

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Care plans are developed by registered nurses and are reviewed by the multidisciplinary team. Families are involved in the development and review of the care plan. InterRAI assessments are linked into the long-term care plan. Six monthly multidisciplinary team evaluations occur in consultation with family.

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

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

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. There is a reactive and planned maintenance schedule. The gardens and grounds are well maintained. Residents in the psychogeriatric unit are able to move freely inside and within their secure environment.

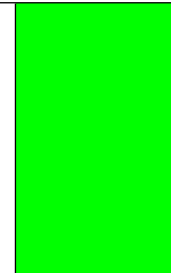
Restraint minimisation and safe practice

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.
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Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. There are four residents using restraints and no residents utilising enablers. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

Infection prevention and control

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



Standards applicable to this service fully attained.

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 uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Dementia Care NZ (DCNZ) facilities. There have been no outbreaks.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	1	1	0	0
Criteria	0	39	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has in place a complaints policy and procedure that aligns with Code 10 of the Code of Rights and is an integral part of the quality and risk management system. Complaints information is available at the entrance and information is provided to residents and relatives at entry. Complaints/compliments forms are available at the front entrance and there is a suggestion box.</p> <p>There is an up-to-date complaint register on an access database format. The database register includes a logging system, complainant, name, dates, investigation, findings, outcome and response. The register identifies if the complaint has been resolved or not and the complainant is offered independent advocacy. In 2018, there were three complaints including one from the DHB in May 2018 which has been investigated by the service and closed out by the DHB. There have been three complaints for 2019. One complaint regarding clinical care was received by the HDC and referred to the service. The complaint was investigated and response forwarded to the HDC. There has been no further action required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>There is an open disclosure policy in place, information on which is included at the time of admission. A site-specific introduction to the psychogeriatric unit booklet provides information for family, friends and visitors to the facility. Eleven accident/incidents for the month of December 2019 were reviewed and evidenced EPOA/family notification. Two relatives interviewed confirmed they are notified of any changes in their family member's health status and they were welcomed when visiting. There are quarterly family support group meetings held on site</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>three monthly with an Age Concern advocate. Regular newsletters keep families updated on facility matters, staffing, health and safety and infection control information and survey results.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Dementia Care New Zealand Limited (DCNZ) is the parent company under which Millvale House Levin operates. Millvale House Levin has ceased hospital level of care (due to RN shortage) and currently has one rest home resident in the 12-bed dual purpose unit who will be transferring to another rest home facility in the near future. On the day of audit, there were 18 residents in the 18-bed psychogeriatric unit (including one resident in hospital, one resident under ACC funding and one resident under a compulsory treatment order – CTO).</p> <p>An acting facility manager/clinical manager (RN) from another DCNZ 30 bed facility and an on-site part-time operations coordinator (non-clinical) are responsible for the daily clinical and non-clinical operations of the facility. The acting facility manager/clinical manager (RN) is on site five days per fortnight. There is a senior RN (2IC) onsite when the acting clinical manager is not on site. The organisation is actively recruiting for a clinical manager. Off duty RNs provide local on-call support should the need arise, with the acting facility manager/clinical manager (RN) providing 24/7 on-call phone support. The management team are supported by a national clinical manager (present on days of audit), national clinical advisor, quality systems manager, national educator and supportive owner/directors. There is a stable RN workforce for the last year.</p> <p>There is an overall DCNZ strategic business plan for 2019-2020 that includes the vision, values and philosophy of care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states. The 2019 organisational goals have been reviewed by the governance team. Millvale Levin has a site-specific quality plan that includes health and safety objectives, reduction of falls, improving the pain management process and individualised activities.</p> <p>The operations coordinator has been in the role four years and responsible for non-clinical services. She has attended a two-day DCNZ conference for operation coordinators. The acting facility manager/clinical manager (RN) has been employed by the organisation for more than 3 years as a senior RN prior to CM appointment. Completed CM orientation included site specific health and safety induction and the CM is registered to commence mental health and addiction papers in August 2020. HealthCERT and the DHB have been notified of changes in clinical management positions and ongoing recruitment activities.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p>	<p>FA</p>	<p>The organisation-wide risk management plan describes objectives, management controls and assigned responsibilities. Progress with the quality and risk management programme is monitored through the monthly quality improvement meetings. The acting facility manager/clinical manager (RN) and operations coordinator log and monitor all quality data. Meeting minutes are maintained and staff are required to read the minutes. Minutes</p>

<p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>sighted have included actions to achieve compliance where relevant. Staff receive clinical and non-clinical quality bulletins which are a summary of quality data reports. Facility meeting minutes document discussion around infection control, health and safety, complaints/concerns and audit outcomes. Staff interviewed confirmed involvement and feedback around the quality management system.</p> <p>Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2019 has been completed and commenced for 2020. Areas of non-compliance identified at audits have a quality improvement raised. Corrective action plans developed had been signed as completed. Benchmarking with other DCNZ facilities occurs on data collected.</p> <p>Surveys are completed including respite care follow-up survey, six weeks post admission survey and EPOA surveys. The 2019 survey had a positive response around communication and the family support group service offered for relatives.</p> <p>The service has policies and procedures to support service delivery that reflects best practice. A system and process for managing policy and document development and review is established. Staff are informed of new/reviewed policies and documents. Policies are available to staff in both electronic and hard copy.</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. There is an identified site-specific health and safety objectives. A senior caregiver is the health and safety officer and has completed paper-based training. The health and safety committee meet monthly and the meeting minutes are available to staff. All new staff complete health and safety induction and safe manual handling (with the physiotherapist). Reported hazards are reviewed and added to the hazard register if unable to be eliminated. Progress to meeting the objective is evaluated through the monthly H&S meetings.</p> <p>Falls prevention strategies are in place that include assessment of risk; medication review; assessments with physiotherapy input; exercises/physical activities; training for staff on detection of falls risk; and environmental hazard awareness. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected</p>	<p>FA</p>	<p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. There is a monthly resident event analysis meeting where all incidents/accidents are analysed for trends and preventative measures. The meeting minutes are available to staff. Eleven incident/accident forms reviewed identified they were fully completed and followed up appropriately by the RN. Benchmarking occurs with other DCNZ facilities.</p> <p>Discussions with the management team confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three section 31s (two in October and one in November</p>

<p>consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>2019) reported to HealthCERT for reduced RN cover in the hospital unit. HealthCERT and DHB are aware the service has not been accepting hospital level or rest home residents from November 2019.</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>PA Low</p>	<p>There are human resources policies to support recruitment practices. A register of practising certificates is maintained for registered nurse, GPs and allied health professionals involved with the service. Five staff files (two RNs, two caregivers and one diversional therapist) were reviewed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Annual performance appraisals had been completed annually.</p> <p>There is an annual education plan that has been completed for 2019 and commenced for 2020. Education provided meets the requirements of the ARHSS contract. The national educator (psychiatric nurse) visits the site regularly and provides specific education around challenging behaviours, de-escalation and disengagement and best friends approach to care. Clinical education is also provided by the national clinical manager and RNs. The physiotherapist provides training on safe manual handling. Repeat sessions are offered and staff complete competencies if unable to attend education sessions. Competency packages include (but not limited to) restraint minimisation, medication, BPSD, fire safety, advocacy, abuse and neglect, food safety and infection control.</p> <p>There are four registered nurses who are registered to attend interRAI training. The acting clinical manager is interRAI trained. There are 11 caregivers who work in the psychogeriatric unit. Ten caregivers have dementia unit standards and one caregiver employed November 2019 is yet to be registered to commence the units. The national educator is a Careerforce assessor.</p> <p>The previous partial provisional finding around staffing for the dual-purpose unit remains open prior to occupancy. Even though the service is no longer accepting hospital level residents, there are currently not enough registered nurses to cover both the PG and hospital.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a registered nurse on duty in the unit 24/7. Sufficient staff are rostered on to manage the care requirements of the residents.</p> <p>AM shift: Two caregivers – 7 am – 3 pm and 9.30 am – 12.30 pm</p> <p>PM shift: Two caregivers – 3 pm – 12 am and 4.30 pm – 9 pm</p> <p>Night shift: One caregiver</p> <p>There is a home assistant on duty 8 am – 1 pm and 3.30 pm – 6.30 pm seven days a week. The home assistant</p>

		<p>role is housekeeping and laundry.</p> <p>There is a DT – 1 pm – 5 pm seven days a week.</p> <p>Currently there are two residents with level two funding. There is an additional caregiver on from 4.30 pm – 10 pm for one resident and one caregiver on for 24 hours for the ACC resident. These caregivers are additional to the roster.</p> <p>Interviews with staff and family members identified that staffing is adequate to meet the needs of residents.</p> <p>One of the caregivers is allocated to assist the rest home resident with cares and attend to their needs. There is a draft roster for the dual-purpose unit should hospital residents be admitted. However, there is currently insufficient RNs to meet the requirement of the ARCC contract (link 1.2.7.3).</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Medication policies and procedures meet legislative requirements. The RNs administer medications and have completed medication competencies and medication education. The RN checks the robotic rolls against the electronic medication chart and signs in the pack as checked. Medication competent senior caregivers assist as second checkers when required. Medications are stored safely. There were no self-medicating residents. There is a hospital stock which is checked regularly for expiry dates.</p> <p>Medication fridge temperatures are monitored daily and within the acceptable range. All eye drops in the medication trolley were dated on opening.</p> <p>Ten medication charts were reviewed on the electronic medication system. All medication charts had photo identification and an allergy status documented. The effectiveness of 'as required' medications had been recorded in the electronic system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is an experienced cook from 7 am to 1 pm and from 2 pm to 6 pm seven days a week. All meals are prepared and cooked on site with the main meal in the evening. There is a four weekly menu that has been reviewed by a dietitian June 2019. The RN completes a food and nutrition information form on each resident. Pureed meals are provided. There are no special dietary requirements. Resident likes and dislikes are known, and alternative foods are offered. There were fluids and high protein drinks available, nutritious snacks and foods available over 24 hours. Meals are plated and delivered in a hot box to the main psychogeriatric unit dining room. Lip plates and specialised utensils are available as needed to promote independence at mealtimes. Staff were observed assisting residents with their meals. The rest home resident prefers to have their meal in their room, however there is a small lounge where they can dine if desired.</p> <p>The food control plan expires 31 March 2020. Daily temperatures are taken and recorded for the fridges, freezer, end cooked meals, chilled and frozen goods on delivery, dishwasher rinse and wash cycle. There is a daily and</p>

		<p>weekly cleaning schedule in place.</p> <p>Residents and relatives have the opportunity to feedback on meals directly at mealtimes, at meetings and EPOA surveys. Feedback indicates satisfaction with the meals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition changes the RN initiates a GP or nurse specialist consultation. The registered nurse (interviewed) stated that they notify family members about any changes in their relative's health status. Two family members (interviewed) stated their relative's needs were being met and they were kept informed on their relative's health status. Not all care plans reviewed had interventions documented to meet the needs of the resident.</p> <p>There were two residents with chronic leg ulcers and one resident with a skin tear on the day of audit. Wound assessments, wound management plans and dressing plans were in place. Wounds had been evaluated at the documented frequency. The chronic wounds were linked to the long-term care plans. There had been input from the GP, dietitian and wound nurse specialist in the management of the chronic wounds. Referrals had been sent to the tissue viability service.</p> <p>Continence assessments including a urinary and bowel continence assessment, are completed on admission and reviewed monthly. Continence products are allocated for day use, night use, and other management. Resident daily bowel records and hygiene cares checklists are maintained.</p> <p>Abbey pain assessments are completed for all residents with identified pain and on pain relief. Monitoring forms in use included behaviour monitoring, abbey pain assessments and monitoring, weight monitoring, food and fluid charts, re-positioning charts, neurological observations. Behaviour assessments and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Millvale House employs a qualified diversional therapist (DT) for four hours a day from 1.30 pm to 5 pm Monday to Friday. The weekend manager coordinates activities in the weekends. Caregivers incorporate activities into their role at other times. The service provides an activity programme designed to meet the needs of psychogeriatric residents. The DT is supported by DTs from other facilities and there are monthly 'zoom' meetings with the national educator.</p> <p>Varying activities occur and are focused on sensory and household activities and reflect on daily activities of living such as exercises, crafts, movies, puzzles, crosswords, pampering happy hours, walks and gardening. Residents who are unable to participate or choose not to have one-on-one time spent with them including pampering, reading and garden walks. There is a volunteer who brings in a pet dog for pet therapy. Church services are held weekly. Festive occasions and themes are celebrated.</p> <p>The rest home resident prefers to spend time in the resident room. The DT and staff check frequently to see if</p>

		<p>there are any activities the resident would like to participate in, including a game of cards. The resident goes out to church, for coffee mornings and visits with friends.</p> <p>A social profile is developed on admission and each resident has an individual activity plan and 24-hour MDT plan (link 1.3.6.1) that includes de-escalation strategies including one on one activities. There are six-monthly MDT family meetings and resident/relative meetings. Relatives interviewed were satisfied with the activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed identified a six-month evaluation of care and activities by the MDT including input from care staff, RN, DT, GP and other allied health professionals as relevant. Family are invited to attend the MDT. There is a written evaluation that identifies if the goals of care have been met or not. Short-term care plans reviewed were either resolved or if an ongoing problem, added to the long-term care plan. There is at least a three-monthly review by the medical practitioner. Ongoing nursing evaluations occur daily/as indicated and are included within the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>Millvale House has a current building warrant of fitness that expires on 31 October 2020. The facility is divided into two "homes". One home (dual purpose) has one ensuite room occupied (as the service is no longer accepting hospital level residents). The rest home resident has access to a communal lounge and outdoor area. The findings at provisional audit regarding completion of outdoor landscaping and appropriate placement of furniture for rest home residents has been addressed.</p> <p>The psychogeriatric unit has 18 single rooms. There is secure access to the entrance of the psychogeriatric unit. There is a secure nurses' station in the PG unit.</p> <p>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.</p> <p>The operations coordinator oversees maintenance for the facility. A maintenance person is available part-time. 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 monthly hot water temperature monitoring and checks on resident mobility equipment.</p>
<p>Standard 3.5: Surveillance</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for</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>		<p>infections that meet the standard definitions. A monthly log of infections is maintained and infection events, trends and analysis are discussed with RNs prior to their RN meeting. Infection control data is collated monthly and reported at the quality improvement meetings. Meeting minutes are available to staff. Internal infection control audits assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which 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 four 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. The restraint coordinator, EPOA and GP are involved in the assessment and evaluation of restraint in consultation with RNs.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	The previous partial provisional finding around staffing for the dual-purpose unit remains open prior to occupancy. Even though the service is no longer accepting hospital level residents, there are currently not enough registered nurses to cover both the PG and hospital.	While the service currently does not provide care for hospital level care-ARC. They remain certified to provide this level of care. The service does not have enough registered nurses to cover both the PG unit and Hospital unit as per the requirements of the ARC and ARHSS contracts	<p>Ensure there are sufficient registered nurses prior to occupancy of hospital residents in the dual-purpose unit</p> <p>Prior to occupancy days</p>
Criterion 1.3.6.1	PA	Four of five care plans of psychogeriatric residents did not document interventions	(i) Three 24-hour multidisciplinary team (MDT) plans had not been reviewed to reflect the	(i) – (iii) Ensure there are

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>Moderate</p>	<p>to meet the residents needs in activities and recommendations from allied health professionals.</p>	<p>resident's current activities; (ii) There was no bowel management plan for one resident as recommended by the psychiatrist; and (iii) Two care plans did not identify weight loss and dietary requirements as per the dietitian reports.</p>	<p>documented interventions to meet the resident's current needs.</p> <p>90 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.