

Millvale House Levin Limited - Millvale House Levin

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: 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: 7 December 2021 End date: 8 December 2021

Proposed changes to current services (if any): The current decommissioned dual-purpose unit (Haumaruru home) of 12-beds is to be reconfigured to provide psychogeriatric level care across 8-beds (stage one). The service is removing providing hospital-medical and rest home level care from their current certificate. Overall psychogeriatric beds will increase from 18 to 26 and decreasing the overall bed numbers from 30 to 26.

Total beds occupied across all premises included in the audit on the first day of the audit: 17

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.

General overview of the audit

Millvale House Levin is certified to provide hospital (medical, and geriatric) and psychogeriatric level care for up to 30 residents. The service is divided into two separate homes - a secure psychogeriatric home and decommissioned 12-bed dual-purpose home. Occupancy on the days of audit was 17 residents.

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

In addition, a partial provisional audit was completed to verify the current decommissioned 12-bed dual-purpose unit as suitable to provide psychogeriatric level care for up to eight residents. The four remaining bedrooms are being reconfigured. One has been reconfigured to a whanau room. The service intends to remove the wall between the other two rooms and make a second lounge. This will not occur until later. The service is removing providing hospital- geriatric and rest home level care from their current certificate. Overall psychogeriatric beds will increase from 18 to 26 and decreasing the overall bed numbers from 30 to 26.

An operations co-ordinator, and clinical manager manage the service on a day-to-day basis. The operations co-ordinator has been in the role four years and is supported by a clinical manager/registered nurse appointed June 2021. They are supported by a governance and clinical management team from DCNZ. Staff interviewed feel supported in their roles. The families interviewed all spoke positively about the care and support provided.

This certification audit identified one shortfall around care plan interventions.

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

Consumer rights

Millvale House Levin has policies and procedures that align with the requirements of the Privacy Act and Health Information Privacy Code. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the code of rights and services is 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

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 and provide feedback to the staff. There is a benchmarking programme in place across the organisation. The internal audit schedule is being completed. Areas of non-compliance identified at audits have had quality improvement action plans developed and signed as completed. Relative surveys are undertaken annually. Incidents and accidents are appropriately managed. Appropriate staff are recruited and provided with a comprehensive

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

Continuum of service delivery

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. Information is gained through the initial support plans, specific assessments, discharge summaries, to formulate care plans to guide staff in the safe delivery of care to residents. The care plans are personalised, and goal orientated. Care plans are reviewed every six months or earlier if required, with input from the EPOA/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months.

There is a documented activity programme.

Medications are managed appropriately in line with accepted guidelines. Registered nurses administer medications and have an annual competency assessment and receive annual education. Medication charts are reviewed three-monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and accommodated. All meals and baking are cooked on site. This includes consideration of any dietary preferences or needs. There is a four-week rotational menu that is reviewed by a dietitian. Nutritional snacks are available 24 hours.

Safe and appropriate environment

The building has a current building systems status report issued in lieu of a building warrant of fitness during Covid lockdown. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services. Cleaning and laundry services are monitored through the internal auditing system. Laundry is completed on site.

All resident rooms are single within the facility. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a spacious lounge and dining area in each 'home' within the facility, and also smaller lounges available for quieter activities or visitors. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. The internal areas are ventilated and heated. There is wheelchair access to all areas. The outdoor areas are safe, easily accessible, and secure.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies. There is a staff member on duty on each shift who holds a current first aid certificate.

Restraint minimisation and safe practice

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

Infection prevention and control

Millvale House Levin has an infection control programme that complies with current best practice. The infection control manual outlines a range of policies, standards and guidelines and defines roles, responsibilities and oversight, training and education of staff and scope of the programme. There is a dedicated infection control nurse who has a role description with clearly defined guidelines. The infection control programme is reviewed annually at organisational level.

The infection control programme is designed to link to the quality and risk management system. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Education provided

includes an evaluation of the session and content delivered. Records of all infections are kept and provided to head office for benchmarking.

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	43	0	0	1	0	0
Criteria	2	90	0	0	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>There is a code of rights policy and procedures in place. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is incorporated into care. Discussions with two registered nurses (RN), three caregivers, one home assistant, one diversional therapist (DT) and two cooks identify their familiarity with the code of rights. Discussion with four family members confirm the service functions in a way that complies with the code of rights. Observation during the audit confirmed this is occurring in practice. Code of rights training is included in the staff orientation and in the ongoing education planner.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consent is obtained for sharing of health-related information, photograph for identification and social display and consent for outings. All five files reviewed included completed consents. Permission granted is signed as part of the admission agreement. There was documented evidence of discussion with the enduring power of</p>

		<p>attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents' advance directive where applicable was available on file.</p> <p>All five files reviewed had copies of the activated EPOA on file. Interviews with family members state they have input in care and choices are offered on a daily basis. Long-term care plans and 24-hour multidisciplinary care plans demonstrate resident choice as appropriate.</p>
<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. Information on advocacy and the Code of Right is provided to staff at orientation and as part of the annual in-service programme.</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 and staff made them feel welcome when they visited. Community entertainers, church groups and a pet therapist visit Millvale Levin".</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 and in each home. Information about the complaints process is provided on admission. Staff interviewed could describe the process around reporting concerns/complaints. The clinical manager is responsible for the management of complaints in consultation with national clinical manager. An on-line complaint's register includes date of complaint, acknowledgment date, investigation, outcome, and complainant</p>

		<p>response/resolution. There were four internal and one DHB complaint in 2020 and no complaints year to date for 2021. Recommendations in relation to the DHB complaint have been implemented. Verbal complaints had been documented in the register. All concerns/complaints had been acknowledged and investigated with in the COR required timeframes. Letters of resolution and outcomes offer advocacy.</p> <p>A complaint to the health and disability commission from November 2019 remains open. The service has complied with all requests for further information within the required timeframes.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>The Code of Rights posters are displayed in each “home” within the facility. The information pack for new residents/families on entry includes information about the Code, complaints procedure and services provided including the safe environment for dementia and psychogeriatric residents. Resident and families right to access advocacy services is identified and advocacy service leaflets are also available at the front entrance. On entry to the service, the clinical manager discusses the information pack with the resident (as appropriate) and their family/whanau/enduring power of attorney (EPOA). Discussions with the caregivers and registered nurses identify they are aware of the right for advocacy and how to access and provide advocacy information to residents/relatives if needed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. The initial and ongoing assessment includes gaining information of resident’s beliefs and values in consultation with the resident (as appropriate) and relative/EPOA. Interventions to support these are identified in the care plans and evaluated to ensure the residents needs are being met. Care staff interviewed describe how a resident’s privacy and dignity was maintained. Staff sign a confidentiality clause contained within the employment agreement on employment.</p> <p>The service's philosophy focuses on residents' right to respect, privacy</p>

		and safety and have adopted the “best friends” approach to resident care. There is a policy that covers abuse and neglect and staff have completed abuse and neglect training with Dementia New Zealand (June 2021). During the visit, staff demonstrated knocking on doors prior to entering resident private areas. Interviews with care staff confirmed a good understanding of abuse and neglect and their associated responsibilities. Interviews with family members identified that caregivers are always respectful and caring.
<p>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. The organisation has a cultural advisor based in the Kapiti region who is available as needed and assists with staff education. On the day of the audit there were two residents who identified as Māori. Specific cultural needs are documented in the care plan and activity plan as sighted in the two Māori resident files reviewed. Family/whānau involvement is encouraged in assessment and care planning. Links to Iwi and local Marae are identified in the care plans. There is a Māori Health plan and current guidelines for the provision of culturally safe care for Māori residents. Bi-cultural awareness training is included in the annual in-service education programme. The education coordinator provides assistance and guidance for Māori residents as needed.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	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 state the resident's individual culture, beliefs and values are met. Regular weekly church services are held. Staff receive training on cultural diversity.</p>
<p>Standard 1.1.7: Discrimination</p>	FA	<p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the staff files</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>sampled. Staff comply with confidentiality and the code of conduct. The registered nurses and allied health professionals' practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the operations coordinator, the clinical manager, registered nurses, and care staff confirmed an awareness of professional boundaries. Discussions with the operations coordinator and a review of complaints identified no complaints of this nature.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>An implemented quality improvement programme includes performance monitoring. A quality monitoring programme is implemented, and this monitor contractual and standards compliance and the quality-of-service delivery. The service monitors its performance through resident/relatives' meetings, surveys, quality meetings, health and safety meetings, RN meetings, restraint approval group and infection control meetings, staff appraisals, satisfaction audits, education and competencies, complaints, and incident management.</p> <p>The education programme includes the required mandatory education topics including clinical in-services that meet psychogeriatric level of services. Education is provided around dementia, delirium and depression, de-escalation, and disengagement. Staff are supported by a workplace wellbeing programme and a counsellor visits the site weekly and is available for staff and families if required. Staff interviewed stated they were well supported by the governance and management team.</p> <p>General practitioner visits for staff are partially subsidised by the company.</p> <p>Monthly operations and clinical bulletins are published for staff and include information such as quality data results (accidents/incidents), infection control surveillance, and education opportunities. There is staff debriefing following incidents of challenging behaviours with good management and team support.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy in place. An introduction booklet provides information on the secure psychogeriatric home. A quarterly newsletter “our home” is published and distributed to family (or emailed) and available at the main entrance. There are six-monthly multidisciplinary team (MDT) meetings with the resident (as appropriate) and family/whanau/EPOA. Monthly family support meetings are scheduled however have not been held recently as a result of Covid restrictions. Families are informed on service updates including the outcomes of surveys.</p> <p>Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Twelve incident/accident forms were reviewed for October November and December 2021 and all forms evidenced family had been informed. Relatives interviewed, confirmed they are notified of any changes in their family member’s health status and spoke positively around all aspects of communication. Review of resident records confirmed communication is occurring.</p> <p>An interpreter service is available if needed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Dementia Care NZ Limited (DCNZ) is the parent company under which Millvale Levin operates. Millvale House Levin currently provides care for up to 30 residents at hospital, rest home and psychogeriatric level of care. Millvale House Levin has not provided hospital (geriatric) or rest home level of care in the “Haumaru home” since early 2020. The 12-bed decommissioned Haumaru home is currently closed. On the day of audit, there were 17 residents in the 18-bed “Aroha Nui psychogeriatric home all under the specialist’s contract (ARHSS).</p> <p>A clinical manager (RN) and an operations coordinator are responsible for the daily clinical and non-clinical operations of the facility. The clinical manager has been in the role for six months and previously worked in an RN role at another DCNZ facility. The clinical manager reports to the national clinical manager. The operations coordinator (non-clinical) of Millvale House Levin has been in the role for four years and has worked for DCNZ for eight years. The operations coordinator reports to the operational management leader at head office. The clinical manager</p>

	<p>and operation coordinator are supported by a corporate structure that includes two managing owner/directors and a governance team of managers including an operations management leader, clinical advisor, national clinical manager, quality systems manager and national education coordinator.</p> <p>The organisation holds an annual training day for all operations and clinical managers. The two-day conference for managers was last held in April 2021 for clinical managers, and June 2021 for operations manager. This is attended by representatives of all DCNZ facilities. The clinical manager completed a self-directed learning package specific to the role and has attended DCNZ clinical manager conference. Both managers have been supported by the organisational team who visit the site regularly. Due to Covid restrictions, clinical seminars in 2021 have been held via zoom sessions.</p> <p>On the days of audit, the Millvale staff were supported by the national clinical manager, educational coordinator/ mental health RN and one of the directors.</p> <p>Dementia Care NZ has an overarching two yearly business plan that is developed in consultation with managers and reviewed regularly. The overall business plan includes the vision, values and philosophy of the company including providing a right based, social model of care where freedom, participation and living in a way that reflects each resident's life is of paramount importance. There is a resident focus on individualised care in small homes and specialist dementia understanding. The vision and values of the organisation underpin the philosophy of the service. DCNZ has an overall 2020 – 2021 business/strategic plan based on a vision to accept all people with kindness and love, to provide peace, comfort, and joy, to be proactive, innovative, and courageous and to enrich each person, the community, and the world. The business plan is regularly reviewed.</p> <p>The Ministry of Health (MOH) was notified of the clinical managers appointment.</p> <p>Partial Provisional:</p> <p>In addition, a partial provisional audit was completed to verify the current decommissioned 12-bed dual-purpose unit as suitable to provide psychogeriatric level care for up to eight residents. The four remaining</p>
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		<p>bedrooms are being reconfigured. One has been reconfigured to a whanau room. The service intends to remove the wall between the other two rooms and make a second lounge. This will not occur until later. The service is removing providing hospital- medical and rest home level care from their current certificate. Overall psychogeriatric beds will increase from 18 to 26 and decreasing the overall bed numbers from 30 to 26. All resident rooms and the overall Haumaru unit have been verified suitable for the proposed changes.</p> <p>Millvale House Levin has a documented transition plan including security changes and additional staffing. Millvale Levin ownership and management structure will continue as is. The managers are well supported by the director and management team, with at least weekly communication via on site visits, email, and phone calls. The managers' report to the directors on matters relating to occupancy and finances.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During a temporary absence of the operations 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>Millvale Levin has a current quality risk management plan, health and safety plan and infection control plan which are all reviewed by the quality team six-monthly. Clinical goals such as restraint falls reduction and reduction in skins infections and management of acute and chronic pain is included in the 2021 quality plan.</p> <p>Progress with the quality and risk management programme is monitored through the six-monthly organisation wide quality meetings. A representative from head office usually attends the monthly quality on site meetings. The operations coordinator and clinical manager log and monitor all quality data and report any corrective actions required to achieve compliance where relevant. Quality data reported includes falls, behaviour incidents, bruises, skin tears, infections, medication errors and restraint use. Data is collated for benchmarking and results reported back to the facility for quality improvement plans if required.</p>

	<p>The operations coordinator produces a monthly bulletin which includes current risks, audit outcomes, family feedback and general overview from facility meetings. The clinical manager produces a monthly clinical bulletin which includes resident related concerns, clinical data, corrective actions clinical audit outcome and clinical benchmarking results. In addition, there is a monthly resident event analysis management meeting which includes the RN and caregiver representation. There are monthly quality improvement, health and safety meetings, monthly infection committee meetings, home manager meetings, cooks' meetings, DT meetings and RN meetings. Meeting minutes and monthly bulletins are available for all staff in the staff room. Discussions with staff confirmed their involvement in the quality programme.</p> <p>The service has policies and procedures to support service delivery. Policy and document development and review group at head office review policies in consultation with relevant staff and distribute to the facilities. Staff are informed of any new/reviewed policies.</p> <p>The internal audit schedule for 2020 has been completed and 2021 is being completed as scheduled. Internal audits cover all non-clinical, clinical, and environmental areas. The audits are delegated to the relevant person or coordinator. Areas of non-compliance identified at audits (less than 100%) have corrective action plans developed and signed off as sighted on the electronic system. Re-audits are completed as required. Audit results are discussed at meetings and documented in minutes and the monthly bulletins.</p> <p>The service receives feedback from surveys including a family restraint survey and annual EPOA satisfaction. There were eight responses from the EPOA survey with an overall satisfaction rate of 100%. Relatives interviewed were very happy with the care provided stating staff were very caring, patient and understanding and always respectful to residents and relatives.</p> <p>The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. A caregiver has been in the role of health and safety representative for four years and has completed external health and safety training. An RN has enrolled in an on-line workplace health and safety and hazard</p>
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		<p>management training. Two health and safety representatives (interviewed) both attend the monthly health and safety committee meeting. Staff have the opportunity to raise any concerns for discussion and preventive/corrective actions are fed back to staff. Hazards are reported and reviewed. The hazard register is reviewed three-monthly and was last reviewed in November 2021. The health and safety representative confirmed that contractors had cordoned off the new dementia home safely during construction. All contractors complete a site health and safety induction.</p> <p>Falls prevention strategies are in place that includes assessment of risk, medication review, sensor mats, physiotherapist assessments, exercises/physical activities, training for staff on prevention of falls and environmental hazard awareness. The physiotherapist provides frequent safe manual handling/hoist training competencies. There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or 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>FA</p>	<p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted, RN assessment and any follow-up action commenced.</p> <p>Twelve incident/accident forms reviewed on the electronic system were fully completed and followed-up appropriately by the RN. Minutes of the monthly quality meeting, health & safety meetings, resident event analysis (REA) meetings and RN/clinical meetings reflected a discussion of incidents/accidents and actions taken. Neurological observations are completed (as far as practical) for un-witnessed falls or head injury (actual or potential).</p> <p>Discussions with the operations 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 two Section 31 notifications completed since 2020. Notifications included one for influenza outbreaks and one for an unstageable facility acquired pressure injury.</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>Five staff files were reviewed (two registered nurses, two caregivers and one diversional therapist). Job descriptions, reference checks and employment contracts were evident in all files reviewed. Performance appraisals were up to date. A copy of practising certificates was sighted for all registered nurses and allied/medical staff.</p> <p>The service has in place a comprehensive orientation programme that provides new staff with role specific information for safe work practice. There are self-directed learning packages for infection control, health and safety and restraint.</p> <p>Care staff interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service. All five files reviewed showed evidence of orientation to roles with competency packages completed. Competency packages are completed relevant to the role including medication administration, dementia and management of challenging behaviour, safe manual handling, restraint minimisation and safe practice, safe food handling, infection control, advocacy and abuse and neglect.</p> <p>There are five registered nurses, four have completed interRAI training.</p> <p>There are 11 caregivers, and all have completed the required dementia standards. The diversional therapist has completed the dementia standards. All RNs have completed first aid training. The organisation has an education coordinator who is a registered psychiatric nurse. The clinical manager and registered nurses are able to attend external training, including sessions provided by the local DHB. The clinical managers within the organisation attend biannual DCNZ National Forums in advanced nursing practice, competency driven (total of 40 hours annually).</p> <p>The service implements the organisations programme called 'best friends' approach to dementia care'. The best friends approach comprises three compulsory one-hour sessions for caregivers, home assistants and registered nurses. The programme is part of the annual education plan and includes promoting the development of empathy and uses the focuses on how to walk in the shoes of the resident with dementia. The education package includes group exercises, education</p>

		<p>on aging, role-playing using first person and discussions on qualities of a best friend to promote improved communication with dementia residents. The course activities are meaningful, and resident focused with an emphasis on exploring inclusiveness and everyday activities. The programme is tied to the vision and values of the organisation.</p> <p>De-escalation and disengagement techniques training is also provided for staff to enable them to safely manage residents with challenging behaviours. Family support meetings are normally scheduled monthly however these have not occurred as planned due to Covid restrictions.</p> <p>Partial Provisional:</p> <p>The director advised that once approval is received to occupy, the Haumaruru home will initially be used to relocate three residents from the Aroha Nui home to enable refurbishments to occur to the second lounge. The service currently has sufficient employed staff to cover both units. Further care staff and a diversional therapist will be recruited as resident numbers increase and as required. Existing recruitment practices will be implemented in the procurement of new staff. The existing training plan will be used for training and orientation of new staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The operations coordinator and the clinical manager work fulltime Monday to Friday. The clinical manager provides 24 hours on call for the service. The Millvale House Levin roster identifies there is sufficient staffing cover for the safe provision of care for psychogeriatric residents.</p> <p>The service has one, 18-bed psychogeriatric home. The dual-purpose home is unoccupied</p> <p>The clinical manager is rostered three shifts per week as the morning shift RN</p> <p>In the Aroha Nui home for the current 17 residents.</p> <p>AM shift – 1x RN from 7am - 3.00pm, and two caregivers from 7am-3:30pm.</p>

	<p>PM shift – 1x RN from 3pm – 11:15pm, one caregiver from 3pm- 12am; and one caregiver from 5pm to 10pm. There is a home assistant on duty from 8am-1pm and from 4pm – 7:30pm.</p> <p>Night shift – 1x RN from 11pm- 7:15am, and one caregiver from midnight to 8am</p> <p>There are diversional therapy hours from 1:30pm to 5pm across seven days</p> <p>The cook works from 7am to 6pm on a split shift</p> <p>The role of the home assistant is to provide non-clinical support including laundry and cleaning duties. Home assistants have completed food safety, chemical safety, health and safety and infection control training as well as other compulsory education.</p> <p>Staff are visible and available to meet resident’s needs, as reported by family members interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support.</p> <p>Partial Provisional</p> <p>The clinical manager and the existing RN’s will provide RN cover across both homes. The clinical managers hours will increase by eight hours per fortnight. Currently the CM works three days in the role with an additional RN rostered during those days.</p> <p>The service plans to recruit and train additional care staff as resident numbers increase, however they currently have sufficient staff to cover the draft roster.</p> <p>A roster has been developed for the new eight bed Haumaruru home as follows.</p> <p>Morning shift: one caregiver from 7am-3pm, and one caregiver from 7am to 1pm.</p> <p>Afternoon shift: one caregiver from 3pm-11pm and one from 4:30 to 8pm.</p> <p>Night shift: one caregiver (11pm to 7am)</p> <p>There will be additional diversional therapy hours from 1.30-4.30pm as</p>
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		<p>numbers increase.</p> <p>Over the weekends when the clinical manager isn't working, the two wings are in close proximity they will operate as one during the day with residents free to move between units. One RN will oversee both wings.</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' electronic files are protected from unauthorised access by password and paper based are locked in a secure area. Resident records are kept up to date and reflect residents' current overall health and care status. Archived paper-based records are appropriately stored and are accessible as required.</p> <p>Resident files are integrated.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and procedures in place to safely guide service provision and entry to services. Referring agencies establish the appropriate level of care required prior to admission of a resident. Information gathered at admission is retained in resident's records. Relatives interviewed stated they were well informed upon admission and had the opportunity to discuss the admission agreement with the clinical manager. The service has a well-developed information pack available for residents/families/whānau at entry detailing admission to PG care. Advocacy services are available, and details offered to family. The admission agreement relates to the ARHSS contract. The five admission agreements viewed were signed and dated. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Policy describes guidelines for death, discharge, transfer, documentation, and follow-up. A record of transfer documentation is kept on the resident's file. Residents who require admission to hospital or transfer are managed appropriately and relevant information is</p>

		<p>communicated to the receiving health provider or service. A transfer form and supporting documentation accompanies residents to the receiving facility and communication with family is documented.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures in place for all aspects of medication management. There were no residents self-administering on the day of audit. There is one medication room on site which is appropriately secured. Medication fridge and room temperature checks are recorded daily and were within normal ranges. All medications were securely and appropriately stored. Registered nurses administer medications and senior caregivers who have passed their competency act as second checkers. Medication competencies are updated annually. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There are no standing order medications in use.</p> <p>The facility utilises an electronic medication management system. Ten medication profiles were sampled. All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the GP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of 'as required (PRN) medication administered were documented in the electronic system. Medication registers align with guidelines.</p> <p>Partial Provisional:</p> <p>The medication system currently in use will not change with the opening of the new psychogeriatric home and the medication room in the existing home will service both areas. This is located near the office and entrance to the current PG unit. The secure room has two medication trolleys available (one for each 'home'). Registered nurses or senior caregivers assessed as competent will administer medication for the residents.</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 a qualified cook on duty from 7am to 6pm seven days a week. All food services staff and care staff have completed food safety training. There is a current food control plan in place which expires 31 March 2022. The service has a local council 'A' grade rating which expires 29 March 2022.</p> <p>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 on 3 August 2021. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen by the registered nurse or clinical manager. Special diets were noted on the kitchen noticeboard which is able to be viewed only by kitchen staff. Pureed meals and diabetic desserts are provided. Resident likes and dislikes are known, and alternative foods are offered. There were fluids and high protein drinks available and nutritious snacks and foods available over 24 hours.</p> <p>Lip plates and specialised utensils are available as needed to promote independence at mealtimes. There were adequate staff available to assist residents with their meals as observed.</p> <p>On the day audit meals were observed to be hot and well presented. Audits are implemented to monitor performance. Kitchen fridge, food and freezer temperatures were monitored and documented daily; these were within safe limits.</p> <p>Feedback on meals directly is obtained at mealtimes, at meetings and EPOA surveys. Feedback indicates satisfaction with the meals.</p> <p>Partial Provisional:</p> <p>The kitchen is located centrally between the existing PG unit and the proposed new PG unit. There is a combined dining/lounge room in the existing unit and a small kitchen that is to be utilised in the new unit for some residents, otherwise the majority of the residents will have their meals in the existing PG dining room.</p>
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<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 service records the reason for declining service entry to potential residents should this occur and communicates this to potential residents' family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Electronic assessment records and long-term care plans reviewed were completed for all five resident files reviewed (link 1.3.6.1). The electronic resident management system provides in-depth assessment across all domains of care. For the five resident files sampled, interRAI assessments and risk assessments were implemented and reflected into the care plans. Risk assessments are completed on admission and reviewed six monthly or when there is a change in residents' condition. Additional assessments for management of behaviour, wound care and modified diets were appropriately completed as required.</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>The interRAI assessment process informs the development of the residents' care plan. All five resident care plans were resident centred and documented in detail their support needs (link 1.3.6.1). Family members interviewed confirmed care delivery and support by staff is consistent with their expectations. Whānau communication and meetings were evidenced in the documentation reviewed. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved. Staff interviewed reported they found the care plans easy to follow. There was evidence of service integration with documented input from a range of specialist care professionals. Psychogeriatrician and mental health team support and advice was evidenced and documented.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order</p>	PA Moderate	<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</p>

<p>to meet their assessed needs and desired outcomes.</p>		<p>status. Family members interviewed stated their relative's needs were being met and they were kept informed on their relative's health status, however, 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 an unstageable pressure injury (facility acquired) 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 and pressure injury.</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>Pain assessments are completed for all residents with identified pain and on analgesia. Monitoring forms in use included behaviour monitoring, pain, weight, food and fluid charts, re-positioning charts, and neurological observations, however not all monitoring had been completed as per the care plan. 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 Levin 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 is 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</p>

		<p>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>A leisure assessment is completed on admission and each resident has an individual 24-hour activity plan (link 1.3.6.1). There are six-monthly MDT family meetings and resident/relative meetings. One to one activity was observed in the main lounge.</p> <p>Partial Provisional.</p> <p>The service has plans to provide an additional diversional therapist (currently being recruited), mirroring the existing hours in the current PG home as increasing occupancy requires.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed identified a six-month evaluation of care and activities by the multi-disciplinary team meeting (MDT) including input from care staff, registered nurse, diversional therapist, 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 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals in conjunction with the clinical manager and specialist referrals are made through the GP. There was evidence of where a resident's condition evidenced a progressive physical deterioration, and the resident was being reassessed three-monthly for different level of care. Discussion with the registered nurses identified that the service has access to a wide range of support either</p>

		through the GP, mental health team and contracted allied services.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies related to chemical safety and waste disposal. Management of waste and hazardous substances is covered during orientation and staff have attended chemical safety training. There is a secure sluice room and chemical store with all chemicals sighted being clearly labelled with manufacturer's labels and stored in the locked areas. Safety datasheets and product sheets are available. Hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. The registered nurse and care staff interviewed could describe the safe management of hazardous material.</p> <p>Partial provisional:</p> <p>The sluice is located in the existing PG unit and staff working in the new area will need to go into the existing unit to access the sluice (when needed). Procedures are in place around managing this.</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 Levin has a current systems status report issued in lieu of a building warrant of fitness due to Covid lockdown restrictions. This is due to expire on 31 October 2022. The facility is divided into two wings which are referred to as 'homes'. One which is currently certified for dual purpose level care was empty and being refurbished. The existing psychogeriatric 'home' has 18 single rooms. There is secure access to the entrance of the psychogeriatric unit. There is a secure nurse's station in the existing PG 'home' and a separate nurses' station at the entrance of what was the dual purpose 'home'. The two units are spacious with wide corridors that allow for the use of mobility equipment. Handrails are in place within the communal areas.</p> <p>Maintenance is managed through the DCNZ head office. Maintenance requests are logged into a maintenance book kept in the nurse's station. Minor maintenance requests and repairs are addressed and signed off. External contractors carry out larger repairs and they are available 24/7 for essential services.</p>

		<p>Electrical equipment has been tested and tagged and clinical equipment has been serviced/calibrated annually. There is a monthly planned maintenance schedule that includes resident mobility equipment.</p> <p>The psychogeriatric 'home' has exit and entry access from several doors within the space. Each of the two units have a separate outdoor deck and landscaped garden area with safe access. There is seating and shade provided over the summer months. They include a number of paths and raised gardens for residents to access.</p> <p>Each 'home' has a high wooden fence around the perimeter of the outdoor area providing security and privacy. The garden areas have established trees and seating areas. Shaded areas are available and there are automated awnings over the lounge windows.</p> <p>Partial provisional:</p> <p>The decommissioned dual purpose 'home' of 12-beds has been refurbished and is to be used to provide an additional eight psychogeriatric level beds. Of the four remaining rooms, two are to be converted into an additional lounge area and one has been reconfigured as a whanau room. The conversion of the two resident rooms into a lounge requires the removal of a wall. This is to occur at a later date and the room will be closed off initially. There is also a small home kitchen for resident activities. All bedrooms have a basin and call bells are in place. There is enough equipment available including electric beds for the new unit.</p> <p>There is a large deck with ramp access extending from the (current dual purpose) lounge into a garden area. Outdoor landscaping has been completed and the area is securely fenced. There is a secure access point with electronic keypad and doorbell that leads to the facility entrance.</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</p>	<p>FA</p>	<p>All bedrooms are single in both 'homes' and have hand basins. There are adequate numbers of showers and toilets in each unit. Fixtures, fittings and floor and wall surfaces are made of accepted materials for meeting hygiene and infection control practices and resident safety. Communal toilets and showers have occupied /vacant signs on the</p>

<p>personal hygiene requirements.</p>		<p>doors. Shower rooms have privacy curtains. There are appropriately placed handrails in the bathrooms and toilets.</p> <p>Partial provisional:</p> <p>There are two mobility bathrooms that includes a shower and toilet. These are large enough for mobility equipment. There is another toilet available for visitors.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Resident bedrooms are spacious enough to manoeuvre transferring and mobility equipment. Residents and their families are encouraged to personalise the bedrooms as desired. The bedrooms environment is uncluttered. There is a mix of bedrooms with carpet and lino flooring. Electric beds or ultra-low beds are available for use.</p> <p>Partial provisional:</p> <p>The newly refurbished rooms in the current dual-purpose 'home' are adequate for psychogeriatric level occupancy. There is enough room for mobility equipment and staff.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>The current PG 'home' has a combined dining/lounge area. There is also a smaller lounge that is readily accessible to residents. Activities take place in the combined dining/ lounge area of the psychogeriatric 'home' dependent on the type of activity. The lounge has access to the outdoor areas.</p> <p>Seating and space are arranged to allow both individual and group activities to occur. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander.</p> <p>Partial provisional:</p> <p>The newly refurbished 'home' has a small lounge at the end of the wing. There is also another combined lounge and dining room area half way down the unit. The areas are all furnished and suitable for psychogeriatric residents. There is a whanau room at the entrance to the reconfigured unit. Advised that two spare resident rooms will be</p>

		made into another lounge at a later stage.
<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 cleaning and linen practices. All laundry is completed on site by home assistant staff who when interviewed could describe how they maintain a “dirty” to “clean” flow. There were adequate linen supplies sighted in the facility linen-store cupboards.</p> <p>The cleaner’s chemical system is kept within a locked area. Safety datasheets are available. The cleaner’s equipment and chemicals are not left unattended when carrying out the cleaning duties. Protective equipment is available in the laundry and sluice room. Feedback on the service is received through internal audits, meetings, and surveys. The chemical supplier completes regular audits on the laundry and cleaning practices, efficiency of equipment and effectiveness of chemical use. Relatives/EPOAs interviewed were happy with the laundry and cleaning services provided.</p> <p>Partial provisional:</p> <p>The laundry is secure and situated in the newly refurbished area and can continue to adequately provide laundry services with no alterations to the current operation.</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>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills are completed every six months. The orientation programme and annual education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, and gas cooking. Short-term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p>

		<p>There are call bells in the residents' rooms and lounge/dining room areas.</p> <p>Partial provisional:</p> <p>The emergency management systems in place are satisfactory to meet the needs of the psychogeriatric residents. No structural changes have been made to the facility and therefore the fire evacuation plan does not need to be amended. The unit is currently decommissioned but has a secure keypad at the entrance that is activated.</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 all resident rooms are appropriately heated and ventilated with panel heaters. All rooms have external windows that open allowing plenty of natural sunlight. The wall panel heaters in all areas have protective covers. Bedroom windows open safely. Family members interviewed, stated the temperature of the facility is comfortable. Residents have access to natural light in their rooms and there is adequate external light in communal areas.</p> <p>Partial provisional:</p> <p>All communal areas and rooms in Millvale House Levin are fitted with individual thermostatically controlled wall mounted heaters with safety covers.</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 programme and its content and detail is appropriate for the size, complexity, and degree of risk associated with the service. The clinical manager is the acting infection control coordinator. There is a job description for the permanent infection control coordinator with clearly defined guidelines. There is an established and implemented infection control programme that is linked into the risk management system. The DCNZ clinical governance group is responsible for the development of the infection control programme and its annual review, the Millvale House Levin infection control nurse is responsible for the implementation of the infection control programme and the evaluation of the programme's objectives. There are infection control meetings held regularly that comprise of the infection control</p>

		<p>nurse, clinical manager, cook and care staff. Information from these meetings is communicated to the clinical meetings.</p> <p>Visitors are asked not to visit if they are unwell. The majority of residents (one family declined) and all staff working in care have received both doses of the Pfizer Covid-19 vaccine. Residents (via family/EPOA) and staff are offered the influenza vaccine. Covid-19 scanning/manual sign in is mandatory on entry to the facility and the use of face masks is required as part of level 2 restrictions. Covid-19 education has been provided for all staff, including hand hygiene and use of PPE. The facility has adequate signage and hand sanitizers at the entrance. Notices for visitors asking them not to enter if they have been in contact with infectious diseases have been ordered to place at the entrances.</p> <p>Partial Provisional: The current infection control programme will continue to meet the needs of the proposed reconfiguration.</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>There are adequate resources to implement the infection control programme at Millvale House Levin. An infection control meeting is held monthly with results then cascaded to staff, clinical and quality meetings. The IC nurse has completed training in infection control. External resources and support are available through the IC consultant, Public Health Unit, GP and the DHB infection control nurse specialist.</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 requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control manual outlines a comprehensive range of current policies, standards and guidelines and includes defining roles, responsibilities and oversight, the IC nurse role, training and education of staff, Covid-19, and a pandemic plan. Policy development involves the organisation's IC nurses, expertise from the regional clinical managers, quality and systems manager, and consultant microbiologist from Southern Community Laboratories. Policies are updated regularly and directed from head office. Policies, procedures, and the pandemic plan have been updated to include Covid 19 recommendations and guidelines for staff.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control nurse is responsible for co-ordinating/providing education and training to staff and is supported by the operations coordinator. There are internal and external sessions available for training. The orientation package includes specific training around hand hygiene and standard precautions. The infection control nurse and clinical manager have both completed Ministry of Health online infection control education. Staff received training in May 2021 on infection control including prevention and management of Covid 19. Consumer education (where possible) is expected to occur as part of the daily care.</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>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Effective monitoring is the responsibility of the infection control nurse. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data including trends, analysis and corrective actions/quality are discussed at staff and clinical meetings. Infections are documented on the infection monthly register. Corrective actions are established where trends are identified. The IC programme is linked with the quality and risk management programme. The service benchmarks with other DCNZ facilities. Infection control data is reviewed at DCNZ clinical governance and action taken in response to potential service gaps.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>CI</p>	<p>Restraint practices are used only where it is clinically indicated and justified and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>During the audit, there were no residents using enablers and no</p>

		<p>residents with restraints. The service has maintained a restraint free since March 2021. The restraint coordinator (currently the CM) is a registered nurse.</p> <p>Staff complete restraint competencies and attend education and training in restraint minimisation and safe practice and de-escalation of challenging behaviours. Interviews with caregivers and nursing staff confirm their understanding of restraints and enablers.</p> <p>The service has been awarded a continuous improvement for maintaining a restraint free environment.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>The service has an electronic resident management system in place; however, five of five care plans of psychogeriatric residents did not document interventions to meet the residents needs in activities, three did not have sufficient interventions documented to meet the needs of the resident, and one did not consistently record the repositioning required by the resident.</p>	<p>(i) Five 24-hour activity care plans did not document support or assistance needs of the resident regarding activities; (ii) One electronic care plan did not document a behaviour management plan for one resident on a behaviour monitoring chart; (iii) One care plan did not identify signs and symptoms of hypoglycaemia for a diabetic resident; (iv) the implications of a resident's hemiplegia were not documented in the mobility section of the care plan; and (v) repositioning had not been consistently documented for a resident with a pressure injury.</p>	<p>(i) – (iv) Ensure there are documented interventions to meet the resident's current needs, and (v) monitoring charts are maintained appropriately.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	CI	<p>Infection events are collated monthly and areas for improvement are identified and corrective actions developed and followed-up. The facility is benchmarked against other DCNZ facilities and benchmarking results are fed back to the infection control nurse and used to identify areas for improvement. Surveillance results are used to identify infection control activities and education needs within the facility. The service has successfully reduced incidences of all infections with a particular focus upon moisture related skin infections.</p>	<p>The service identified that over the last 12 months overall infection rates have trended downwards, being 2.02 incidents/1000 bed nights compared to 4.62 incidents/1000 bed nights. This is less than half the average of that experienced by other DCNZ facilities. Skin infections have fallen from 2.33 incidents/1000 bed nights to zero incidents/1000 bed nights and there have been no skin infections at Millvale House Levin for six months of the year to date.</p> <p>The service has implemented and maintained a focus of staff training in this area, particularly relating to skin moisturisation, correct drying after cares and early reporting and escalation of warning signs such as skin redness to the registered nurses. The service has successfully reduced and maintained the incidence of skin infections in the psychogeriatric resident population below the organisational average (1.82 per</p>

			1000 bed nights).
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	CI	<p>A review of the clinical indicator data in Dec 2021 indicated Millvale Levin to be restraint free since March 2021. The clinical manager and national clinical manager interviewed confirm that a range of initiatives are implemented to ensure the restraint free environment is maintained. Meeting minutes reviewed evidence discussions around strategies to maintain a restraint free environment. Care staff interviewed could explain current strategies that assist to keep the environment restraint free.</p>	<p>In 2020 Millvale Levin, alongside the senior management team developed a goal to reduce the use of restraint. Three main areas of focus were identified as follows: (i) Staff awareness of detailed patterns of behaviour with CM and RNs increased oversight to be a high area of focus and attention. (ii) Induction and orientation to include De-escalation and Disengagement Training as well as annual and refresher training. (iii) Additional case management from the National Mental Health Nurse a new position created in 2016 to support complex client behaviours nationally. The national mental health nurse reports directly to the national clinical manager who monitors restraint at clinical governance/organisational level.</p> <p>At the local level restraint is monitored monthly at clinical meetings and at six monthly restraint meetings. The service wanted to continue to support residents' independence and safety with proven strategies and initiatives that reduce and maintain a restraint free environment. This includes Individual strategies to respond to specific resident needs including falls prevention, early intervention to identify changes in behaviour, quality use of medication, safe environment for wandering including a dementia friendly design with low stimulus areas, and review of timing of other activities and individual schedules/routine. Where staff experienced difficulty with managing behaviours, they were able to seek additional support and case management from the National Mental Health Nurse</p> <p>DCNZ is committed to their responsibility of providing adequate staff levels and skill mixes to meet the needs of the residents. Education sessions for staff were</p>

			<p>provided to include dementia related training including the best friends approach, de-escalation and engagement training, restraint minimisation practices and management of challenging behaviours. This resulted in an increase understanding of the importance of early intervention, encourage staff input into residents' cares and empower staff to consider triggers and consider the issue from the viewpoint of the resident.</p> <p>Strategies to manage residents in a group setting with challenging symptoms have been utilised and are now embedded into practise. The families interviewed commented that care staff were good at re-directing behaviours. The service provided data which evidenced the service had four residents using restraint in January 2020. As a result of implementation of identified interventions this had reduced to one in February 2021. The service has maintained the restraint free environment since March 21.</p>
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End of the report.