

Millvale House Miramar Limited - Millvale House Miramar

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 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 Miramar Limited

Premises audited: Millvale House Miramar

Services audited: Hospital services - Psychogeriatric services; Rest home care (excluding dementia care)

Dates of audit: Start date: 23 November 2021 End date: 24 November 2021

Proposed changes to current services (if any): The service is not providing rest home level care. To remove rest home level care from their current certificate. Overall bed numbers will drop from 28 beds to 26 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 21

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Millvale House Miramar provides rest home and psychogeriatric care for up to 28 residents. On the day of audit, there were 21 residents across the two psychogeriatric units. The service is not providing rest home level care.

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, and staff.

An operations coordinator and a clinical manager manage Millvale House Miramar and are on site Monday to Friday. The operations coordinator has been in the role for the last 12 months and the clinical manager (experienced registered nurse) was appointed in May 2021. There is support available from the national clinical manager who was present during the audit.

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

The facility continues to embed the use of the electronic resident management system and continues to make environmental improvements.

This surveillance audit identified improvement required around care interventions and utilisation of short-term care plans.

The service has achieved a continuous improvement rating around restraint minimisation.

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.

Information about the Health and Disability Commissioner (HDC) Code of Rights (the Code) and complaints process is readily available to residents and families. There is regular communication and support for families. Family are involved in the resident care plans and evaluations. Complaints processes are implemented, and complaints and concerns are actively managed and documented. A complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Services are planned and coordinated and are appropriate to the needs of the residents. Quality/risk goals are documented for the service with evidence of regular reviews. Quality data is collected and reported to head office for benchmarking. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is implemented and includes in-service education and competency assessments. There is sufficient care staff on duty to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Registered nurses are responsible for each stage of provision of care including initial assessments, interRAI assessments, care plans and evaluations. Care plans reviewed were based on the interRAI outcomes and other assessments. Relatives interviewed confirmed they were involved in the care planning and review process. There is at least a three-monthly resident review by the medical practitioner and psychogeriatric community nurse as required. There are regular visits and support provided by the community mental health team.

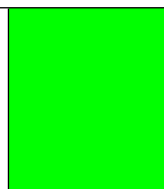
The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident. Individual activity plans have been developed in consultation with resident/family. There are regular entertainers and outings.

Medicines are stored and managed appropriately, in line with legislation and guidelines. The service uses an electronic medication system. Medication charts are reviewed at least three-monthly.

Meals are provided from the main kitchen and delivered in insulated boxes to the home kitchenettes for serving. Resident's individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period. There is dietitian review and audit of the menus. All staff have been trained in food safety and hygiene.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

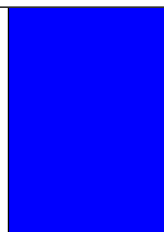


Standards applicable to this service fully attained.

The building has a current building warrant of fitness. There is a reactive and planned maintenance schedule. The environment is suitable and secure for residents requiring psychogeriatric levels of care. Outdoor areas are safe and secure and accessible for the residents. There is adequate equipment for the safe delivery of care.

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.



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

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. There was one resident recorded in the restraint register and no residents utilising enablers. Staff regularly receive education and training on restraint minimisation, de-escalation, and disengagement. Restraint consent, approval and evaluation documentation is current. The approval committee meets regularly.

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 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 are organisational Covid-19 prevention strategies in place. There have been no outbreaks since the previous audit.

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	15	0	1	0	0	0
Criteria	1	40	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The service has a complaints policy that describes the management of complaints process. Information about complaints is provided on admission. Management operates an open-door policy. Interviews with five relatives confirmed an understanding of the complaints process. There is an up-to-date online complaint register. There have been two internal complaints in 2020 (since the last audit) and three internal complaints for 2021 to date. The staff interviewed (four caregivers, the cook, and the diversional therapist) were all aware of their responsibilities around complaints in relation to their role.</p> <p>The operations coordinator and clinical manager share the management of complaints reporting process and outcomes to the quality systems manager and national clinical manager at the head office. All complaints were acknowledged within the required timeframe and letters of acknowledgement/investigation and resolution offered advocacy contact and details.</p>
Standard 1.1.9: Communication Service providers communicate effectively with	FA	<p>There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The management team (operations coordinator, clinical manager, and national clinical manager) and three registered nurses (RNs) interviewed, confirmed family are kept informed. Five relatives stated they are notified promptly of any incidents/accidents or any changes to the resident health status. There was documented evidence of family notification recorded on the significant events record in each file including accidents/incidents, infections, general practitioner visits (GP), behavioural changes and medication. Ten incident and accident forms reviewed</p>

consumers and provide an environment conducive to effective communication.		from October and November 2021 evidenced that family are notified following adverse events. Resident/family meetings encourage open discussion around the services provided. The family members interviewed spoke very positively about the care provided and were well informed around Covid-19 strategies and felt supported. There is access to an interpreter service as required.
<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>	FA	<p>Dementia Care NZ Limited (DCNZ) is the parent company under which Millvale House Miramar operates. Millvale House Miramar provides psychogeriatric level care up to 26 residents across two secure units and two rest home beds in an upstairs unit. On the day of the audit, there were 21 residents receiving psychogeriatric level care in the home, there were no rest home level care on the day of audit. All residents were cared for under the Aged Residential Hospital Specialised Services (ARHSS) contract. The service is requesting that rest home level care be removed from their current certificate.</p> <p>DCNZ has a corporate structure that includes the two managing directors and a governance team of managers including a clinical advisor, national clinical manager, quality systems manager, operations management leader, national procurement manager and national education coordinator. The operations coordinator (non-clinical) has been in the role twelve months and reports to the operations management leader at head office. The clinical manager is an experienced registered nurse (RN) and was appointed in May 2021. She had previous (8 months) experience in a psychogeriatric unit as an RN and is a registered comprehensive nurse with no restrictions on her practicing certificate. HealthCERT was notified of the clinical managers appointment at the time.</p> <p>DCNZ has an overarching two yearly business plan that is developed in consultation with managers and reviewed regularly. The vision and values of the organisation underpin the philosophy and have recently been reviewed and updated. The managing director has provided training sessions on the revised vision and values.</p> <p>Millvale Miramar has a quality plan, health and safety plan and infection control plan which are all reviewed by relevant staff six monthly. Clinical goals such as falls reduction and restraint minimisation has continued in the 2021 quality plan (link CI 2.2.5.1).</p> <p>The organisation holds an annual training day for all operations and clinical managers. Both managers have been supported by the organisational team who visit the facility regularly.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	FA	<p>The organisation-wide quality and risk management plan describes objectives, management controls and assigned responsibility. Quality goals around infection control, health and safety, and education link to the business plan. Progress with the quality and risk management plan is monitored through the monthly quality improvement meetings. There are monthly quality meetings which staff are invited to, that include discussion around quality data including infections, accidents/incidents, resident cares, restraint, policies, goals, and objectives. Minutes of the quality, health and safety, and infection control meetings sighted have included actions to achieve compliance</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>where relevant. The service has policies and procedures to support service delivery which are reviewed at head office. Staff are informed of any policy reviews/changes.</p> <p>Data is collected on complaints, accidents, incidents, infection control and restraint use. Benchmarking with other DCNZ facilities occurs on data collected.</p> <p>There is a DCNZ internal audit schedule, which is maintained. Clinical and environmental audits are completed as scheduled, and corrective actions are completed for audit outcomes less than expected. Corrective actions are documented on an electronic system, all corrective actions have been signed off once completed.</p> <p>Annual enduring power of attorney (EPOA) satisfaction surveys are conducted. Results indicated a high satisfaction rate of input into resident care and decision making, being informed promptly of changes, and privacy and dignity being upheld. Respondents were satisfied with staff and accessibility of the management team.</p> <p>The service has an implemented health and safety management system. There are risk management, and health and safety policies and procedures in place including accident and hazard management register last reviewed July 2021. The director has overall responsibility for health and safety with the operations and clinical managers responsible for day-to-day environmental health and safety. There is a health and safety representative (interviewed) who has completed the appropriate health and safety training. Health and safety including staff incidents and hazards are discussed at facility meetings. The staff interviewed could describe the hazard reporting procedure. Contractors receive induction to the service and are accompanied to their work area.</p> <p>There is monthly analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. A physiotherapist is contracted for fortnightly visits and completes resident assessments, post-falls assessments and staff safe manual handling and hoist training.</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</p>	<p>FA</p>	<p>Incident/accident data has been collected and analysed. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Incident forms are completed electronically by care staff and the residents are reviewed by the RN at the time of the event. A review of 10 electronic incident reports evidenced neurological observations had been completed for unwitnessed falls, wound charts were implemented for skin tears and the mental health team were involved in residents care for challenging behaviours. Opportunities to minimise future incidents (where possible) were identified.</p> <p>Interview with staff informed incidents/accidents are reported appropriately. Discussions with management, confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. Notifications were made to HealthCERT since the last audit for changes in clinical manager, five incidents of absconding related to two residents and one stage three pressure injury.</p>

of choice in an open manner.		
<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>	FA	<p>There are human resources policies to support recruitment practices. Five staff files were reviewed (the clinical manager, one RN, one diversional therapist and two caregivers). All had relevant documentation relating to employment including reference checks, a police check, job description and signed contract relevant to their role. A list of practising certificates is maintained, and performance appraisals were current in all staff files reviewed.</p> <p>The service has an education coordinator who is responsible for ensuring the orientation programme is completed for new staff. There is a buddy system for new staff and staff interviewed stated that they had completed a robust orientation.</p> <p>There is a yearly organisational education plan that includes all required education as part of these standards. The plan is coordinated by the education coordinator (RN). Staff are able to make suggestions on additional topics for inclusion in the in-service calendar. Training attendance is recorded on a database (sighted), and the education coordinator undertakes a reconciliation of attendance annually. This process ensures staff are meeting compulsory requirements and from the information reviewed all staff have attended all compulsory training within the last year. The organisation runs a series of three 'Best Friends' training sessions which train staff around body language, and effective de-escalation techniques to calm challenging behaviour, and includes dementia training. Competencies are completed and a record of completion is maintained in the database. Dementia Care NZ run an education day for diversional therapists, which they attended.</p> <p>There is evidence on RN staff files of attendance at the RN training day/s and external training. All staff administering medications had a current medication competency in place, and there is at least one staff member in each unit with a current first aid certificate throughout all shifts. Registered nurses interviewed stated they complete annual competencies for syringe driver, medication competencies, subcutaneous fluid administration, handwashing, and restraint minimisation competencies.</p> <p>There are three RNs including the clinical manager and all are interRAI trained.</p> <p>Staff are encouraged to complete New Zealand Qualification Authority (NZQA) qualifications. There are a total of 16 caregivers at Millvale House Miramar. Currently there are four who have achieved level 4, four who have achieved level 3 the others are working towards a qualification.</p> <p>Fourteen caregivers have completed the required dementia unit standards, two staff have been recently employed.</p>
Standard 1.2.8: Service Provider Availability	FA	<p>The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a registered nurse on duty in the home 24/7. Sufficient staff are rostered on to manage the care requirements of the residents. The operations coordinator and the clinical manager work fulltime Monday to Friday. The clinical manager shares on-call with two experienced RNs. An on-call schedule and contact numbers are</p>

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		<p>available.</p> <p>Staffing is as follows:</p> <p>Loloma unit – 13 beds with 11 residents</p> <p>Kaibigan unit – 13 beds with 10 residents</p> <p>Morning shift: two caregivers full shift (7 am-3 pm), and two caregivers from (7 am- 1 pm) to cover both wings.</p> <p>Afternoon shift: two caregivers from 3 pm to midnight, one caregiver (2 pm-10 pm) and one from (2 pm-3.30 pm).</p> <p>Night shift: one caregiver and one home assistant (midnight to 8 am).</p> <p>There is one home assistant on the morning shift 8 am to 12.20 pm and one on the afternoon from 4.45 pm to 7.15 pm. Home assistants complete serving of meals, laundry, and cleaning duties.</p> <p>Activities staff: one x 10.30 am to 5.30 pm Monday- Friday, one x 1.30 pm to 5.30 pm Saturday and Sunday.</p> <p>Interviews with staff and relatives identified that staffing is adequate to meet the needs of residents.</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>	FA	<p>The medication management system includes policy and procedures that follow recognised standards and guidelines for safe medicine management practice. An electronic system is used. The RN on duty checks medications on delivery against the medication charts. Other medication stock is checked weekly for expiry dates. Eye drops and ointments are dated when opened. Registered nurses administer medications and they have completed annual medication competencies and education.</p> <p>The caregiver's complete education and demonstrated competency for checking medication. There were no self-medicating residents. There are no standing orders. All medications were stored safely. The medication fridge and room temperature are monitored, and temperatures recorded were within expected ranges.</p> <p>All 10 medication charts reviewed had photo identification and allergies noted. Administration of medication occurred at the prescribed times. 'As required' medications had prescribed indications for use. The effectiveness of PRN medications was recorded on the electronic system and in the residents' progress notes. The 10 medication charts had been reviewed by the GP three monthly. Medication registers are completed and signed as required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's</p>	FA	<p>There is a current food control plan in the kitchen expiring in May 2022, which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning and kitchen procedures. There is one fulltime cook who does 40 hours over four days and one part time cook who works 30 hours Friday to Sunday. Both cooks hold relevant NZQA units and attend chemical safety, first aid and relevant in-service training. A home assistant undertakes the cleaning of the kitchen (schedule in place). The kitchen is located within the psychogeriatric home</p>

<p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>and is locked via a combination lock so that only staff can access this area. There are two kitchenettes in the dining areas where food is served up to residents. Containers of food are transported in hot boxes to the kitchenette, where caregivers plate and serve the meals.</p> <p>There is a summer/winter rotating menu which was reviewed by the dietitian September 2021. The cook (interviewed) receives a nutritional assessment for each new resident and is notified of any changes, special diets, or weight loss. Modified diets are provided. Resident likes and dislikes are known, and alternative foods are offered. Cultural and spiritual needs are met. There were adequate fluids sighted in the kitchenette fridges and supplement protein drinks were available. There is daily monitoring of hot food temperatures, fridge and freezer temperatures, dishwasher rinse temperatures and delivery temperatures for chilled/frozen goods. All perishable foods in the kitchen fridges and freezer were dated. The dry good store had all goods sealed and labelled. Goods are rotated with the delivery of food items. The cook was observed wearing appropriate personal protective clothing. Chemicals were stored safely within the kitchen. There were safety data sheets available. Weights are monitored monthly or more frequently if required. Residents assessed by the dietitian who require supplements received these, and this was recorded in the resident's file and administered from the electronic medication chart.</p> <p>The lunch meal was observed, and enough staff were available to assist residents with their meals. There is sufficient space in the dining room for safe mobility of residents and staff. Specialised eating utensils are available. Residents and relatives expressed a high level of satisfaction with the meals provided.</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 Low</p>	<p>Three of five care plans reviewed evidenced that interventions are consistent with the needs of residents as demonstrated in the review of supplementary documentation (progress notes, monitoring forms, allied health notes and medication charts) and discussion with caregivers, registered nurses, diversional therapist, and management. Families interviewed stated their relatives' needs are being met. When a resident's condition changes, the RN initiates a GP or nurse specialist consultation. Families confirmed they are notified promptly of any changes to health status.</p> <p>Wound assessments and evaluations have been completed for the three minor skin tears. The RNs interviewed stated there are no chronic wounds or pressure injuries managed and they were knowledgeable around wound management and when to involve a wound nurse specialist. Residents with a high risk of pressure injuries have an air alternating mattress on their bed, and two hourly position changes are performed (a monitoring chart was created as a worklog and completed on the electronic system).</p> <p>Specialist wound and continence management advice is available as needed. Adequate continence supplies were sighted during the audit.</p> <p>There is good specialist input into the residents. The care team and diversional therapist could describe strategies for the provisions of a low stimulus environment. The mental health team are available and the psychogeriatric community nurse visits regularly.</p>

		Monitoring forms include pain, observations, neurological observations, 24-hour fluid intake, blood sugar levels, weight, re-positioning charts, food and fluid, resident hygiene and bowel charts, restraint monitoring and toileting charts.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs two activities staff; one qualified diversional therapist (DT) who works from 10.30am-5.30pm Monday to Friday, and the diversional therapist in training works 9am-4pm on a Saturday and 1.30-5.30 on a Sunday). Care staff on duty are involved in individual activities with the residents as observed on the day of audit. There are plenty of activity resources available to staff.</p> <p>The diversional therapist interviewed describes the programme for the psychogeriatric residents is designed to focus on individual and small group activities that are meaningful, including household tasks, reminiscing and sensory activities such as music therapy, foot and hand massage, baking, garden walks, games, and movies.</p> <p>There are volunteers involved in the programme with spiritual services, pet therapy twice weekly, weekly piano playing and singers performing weekly. Care staff also assist with pamper sessions. The service has a wheelchair van which is used to take residents out weekly. The DT has a current first aid certificate.</p> <p>Activity assessments, activity plan, 24-hour multidisciplinary care plan, progress notes and attendance charts are maintained. Resident and family meetings are held.</p> <p>A comprehensive social history is completed on or soon after admission and information gathered from the relative (and resident as able) is included in the activity care plan. A 24-hour multidisciplinary care plan is reviewed at least six-monthly.</p> <p>Caregivers were observed at various times throughout the day diverting residents from behaviours. The programme observed was appropriate for older people with mental health conditions. Activities were observed to be occurring in the lounge and the outside secure courtyard. Families expressed positive comments and satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans were evaluated by the RN within three weeks of admission in the files reviewed. Nursing care plans are reviewed six-monthly by the multidisciplinary team (MDT) and evaluated at least six monthly or earlier due to health changes. Evaluations include the progression towards the goal and if the goal is different, the appropriate changes are recorded. The family are invited to the three-monthly MDT reviews. Other health professionals are involved as appropriate, such as the physiotherapist and dietitian. Short-term care plans are reviewed and resolved, or if an ongoing problem, added to the long-term care plan.</p> <p>There is at least a three-monthly review by the medical practitioner of the resident and their medications. Ongoing nursing evaluations occur daily/as indicated and are included within the progress notes.</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>The service is overseen by the managing director and national procurement manager who oversee the site and arrange for preventative maintenance to ensure that buildings, plant, and equipment are maintained appropriately. The facility continues to make improvements and include levelling of pathways, surrounding fence improvements and purchasing of new equipment.</p> <p>Requests can be generated by the facility and there is also a reactive maintenance request book. A maintenance person is employed for 12 hours per month and the on-site operations coordinator organises and undertakes some aspects of maintenance, (e.g., temperature recording). The facility displays a current building warrant of fitness which expires 22 June 2022. Fire drills are conducted six monthly and the fire service has approved the evacuation scheme. Electrical equipment has been tested and tagged and medical equipment calibrated. Contractors are available 24/7 for essential services. Hot water temperatures are monitored weekly and are below 45 degrees Celsius (sighted). Residents were able to move freely inside and within the secure outside environments. There is easy viewing to the outside along with easy level underfoot access. There are sheltered outdoor areas and paths that are maintained for safe walking. Outside areas include seating and shade. The psychogeriatric unit is spacious allowing for the use of mobility equipment within two lounge/dining areas that can all be seen from the central nursing station.</p> <p>The unit is secure with appropriate fence surroundings.</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>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Infections are collated in a monthly register and a monthly report is completed by the infection control coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is reported at the quality, infection control committee and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. Benchmarking occurs against other Dementia Care New Zealand facilities. Millvale House Miramar continues to work on reducing skin infections and urinary tract infections. There have been no outbreaks since the last audit.</p> <p>Covid-19 prevention strategies and risk management plans are part of the overall infection control prevention programme. Residents and staff are vaccinated. Relatives and visitors are required to contract trace, sign Covid 19 symptom declarations and wear masks.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes restraint procedures. The restraint coordinator is a registered nurse. Interviews with caregivers and registered nurses confirmed their understanding of restraints and enablers. There was one resident recorded as requiring a restraint on the day of the audit. No residents were using enablers. The resident recorded in the register had no episode of restraint required since April 2021 (link CI 2.2.5.1). Staff complete restraint competencies and attend education and training in restraint minimisation and safe practice and challenging behaviours.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	CI	<p>At the monthly facility quality meetings, RN meetings, staff meetings and six-monthly restraint meetings, restraints are discussed and reviewed. Any incidents of emergency physical restraint (which are infrequent and documented and investigated through the incident reporting system) are also reviewed at these meetings. Meeting minutes include a review of the restraint and challenging behaviour education and training programme for staff. Staff receive orientation in restraint use on commencement of employment. The educator provides training for staff and include a Best Friend approach to dementia and dementia-specific topics. There is internal benchmarking, and the service has exceeded the requirements for the attainment of this standard.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Five files were reviewed. All files had an interRAI assessment completed within the required timeframes. Care plans addressed the scores and outcomes of the interRAI assessments and documented individualised goals. Caregivers and registered nurses interviewed were knowledgeable with the care requirements of all residents. All supplementary documentation including monitoring forms, allied health notes, progress notes and medication charts evidenced the residents are well cared for, however, not all files reviewed evidenced documented interventions to a level of detail that can sufficiently guide staff in the management of resident cares therefore this finding is related to care documentation and is assessed as low risk.</p> <p>Short term care plans sighted were in use for short term conditions like skin tears, weight loss and infections these were either signed off as resolved or added to the long-term care plan if ongoing.</p>	<p>i) One resident with weight loss did not have detailed interventions recorded to manage the weight loss or possible contributing factors.</p> <p>ii) One resident with a history of seizures did not have interventions recorded to manage</p>	<p>(i)-(ii) Ensure interventions are documented to a level of detail to guide staff in the management of the resident's cares. (iii) –(iv) Ensure interventions are updated to reflect acute changes in health status or a short-term care plan developed.</p> <p>90 days</p>

			<p>seizures and related medication levels/changes.</p> <p>iii). There were no interventions documented for one resident with recurrent episodes of vomiting.</p> <p>iv). There were no interventions documented for one resident with a chest infection.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 2.2.5.1 Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and	CI	Millvale House Miramar is committed to detailed analysis of restraint events in order to minimise restraint use through individualised strategies, collaboration with staff and family and support for staff through effective communication and staff education. This	Data was collected throughout the year for each resident, which measures the use of restraint in hours or episodes per month per resident. A resident event analysis report is part of several meetings and included in the clinical quality bulletin and operational bulletin and used as a quality improvement tool. The events analysis includes residents' individual risks, associated behaviour, and the time of day the restraint is used. Overall, communication has had the largest impact on the reduction of restraint. Care staff interviewed confirmed they are encouraged to use the 'Best Friends approach to communication' to de-escalate potential aggressive behaviour. Training and support are provided with continuous education on dementia related topics. Registered nurses are supported through monthly support meetings/coaching sessions using the GROW model. The staff interviewed confirmed they feel supported and have the

<p>(h) Whether there are additional education or training needs or changes required to existing education.</p>		<p>quality improvement initiative aligns with the DCNZ Strategic Plan.</p> <p>The overall approach has resulted in a sustained reduction of restraint hours and episodes per residents, a continuous focus on a person-centred approach to restraint use and empowerment of staff to implement alternative strategies to restraint.</p>	<p>necessary skills to care for the residents.</p> <p>Family has the opportunity to provide feedback during 3-month GP reviews, monthly family support meetings and 6 monthly multi-disciplinary meetings. The last family/whānau/EPOA survey evidenced an overall satisfaction of 85% with service delivery. Family reported a 90% satisfaction in staff accessibility and 90% felt their relatives are treated with respect and dignity.</p> <p>Consistent completion of restraint documentation evidenced a culture of compliance. The service reports the H-belt use per hour (minutes). The trend analysis evidenced consistent decrease of hours of H-belt restraint use for one resident. The resident was recorded in the register as required restraint when necessary, however there were no episodes required since April 2021, the resident is still in the facility. There were two residents that required arm/hand restraints during cares when admitted in February/March 2020 and episodes needing restraint gradually decreased after admission (49 to 37 episodes per month February - June 2020 recorded of the use of arm restraint, decrease to less than 20 episodes per resident for second half of 2020 and less than 10 episodes YTD for each resident per month up to April 2021). There was only one episode of emergency restraint recorded for 2020/2021 and no incidents related, or harm caused by restraints use since January 2020.</p>
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End of the report.