

# Millvale Lodge Lindale Limited - Millvale Lodge Lindale

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## Introduction

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

The audit has been conducted by 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:

|   |   |
|---|---|
| <b>Legal entity:</b>  | Millvale Lodge Lindale Limited  |
| <b>Premises audited:</b>  | Millvale Lodge Lindale  |
| <b>Services audited:</b>  | Hospital services - Psychogeriatric services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| <b>Dates of audit:</b>  | Start date: 24 November 2020    End date: 25 November 2020  |
| <b>Proposed changes to current services (if any):</b>   | The service has been assessed as competent to provide medical services. Add medical services to the provider certification services.                                  |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 57  |



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

| Indicator | Description  | Definition  |
|-----------|--|---|
| Yellow    | 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 |
| Red       | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk   |

## General overview of the audit

Dementia Care New Zealand Ltd is the parent company of Millvale Lodge Lindale. The service provides rest home, hospital, dementia and psychogeriatric level care for up to 57 residents. Medical services have been added to the levels of care. On the day of audit, there were 57 residents.

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

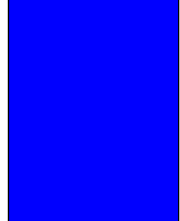
An operations manager and a clinical manager are responsible for the daily management of the service. The operations manager has been in the role for four years is supported by an experienced clinical manager appointed a year ago. There is a supportive governance team who were present during the audit.

Families interviewed during the audit were satisfied with the quality of the care provided at Millvale Lodge Lindale and spoke highly of the staff and management team.

There was one area identified for improvement at this certification audit relating to fire service approval of the evacuation scheme for the new 12 bed dementia care home.


The service has achieved three areas of continuous improvement related to good practice, restraint minimisation and reducing the impact of influenza-like illnesses.

## Consumer rights

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

Millvale Lodge Lindale 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

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |
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The organisational quality and risk management plan includes goals and objectives that are regularly reviewed and discussed in facility meetings. Progress with the quality and risk management plan is monitored through the quality meeting. The operations

manager 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 corrective 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 in the rest home/hospital and the psychogeriatric home to meet the needs of the residents.

## Continuum of service delivery

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

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

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

There is a large commercial kitchen and all food is cooked on site. Food services are provided from the main kitchen and are delivered in hot boxes to each of the four kitchenettes which are adjacent to the lounge/dining rooms. 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.

## Safe and appropriate environment

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| <p>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.</p> |  | <p>Some standards applicable to this service partially attained and of low risk.</p> |
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The service has waste management policies and procedures for the safe disposal of waste and hazardous substances. In lieu of a current building warrant of fitness (unavailable under COVID-19 restrictions) the building has a building systems status report which expires on 16 May 2021. Emergency and disaster plans are in place guide staff in managing emergencies and disasters. There are fire drills six monthly. Residents were able to move freely inside and within the secure outside environments. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and arranged that enables residents to mobilise. General living areas and resident rooms are appropriately heated and ventilated. There is staff on duty with a current first aid certificate. The service has policies and procedures for effective management of laundry and cleaning practices.

## Restraint minimisation and safe practice

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| 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. |
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Restraint policies and procedures are in place. The definitions of restraints and enablers are congruent with the definitions in the restraint minimisation standard. The service had no residents using enablers and no residents using restraints. A register is maintained by the restraint coordinator/registered nurse. Staff regularly receive education and training on restraint minimisation and managing challenging behaviours.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | All standards applicable to this service fully attained with some standards exceeded. |
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The clinical manager and infection control team support the infection control coordinator. Infection control training is provided during orientation and at regular intervals thereafter. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator



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

## Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 3                           | 41                  | 0  | 1                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 3                           | 89                  | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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 three registered nurses (RN), four caregivers, two home assistants, one diversional therapist (DT) and one cook identify their familiarity with the code of rights. Discussion with one rest home and one hospital resident and eight family members (of one rest home, two hospital, three dementia care and two psychogeriatric residents) confirm the service functions in a way that complies with the code of rights. Observation during the audit confirmed this is occurring in practice. The Code 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</p> | FA                | <p>There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and social display and consent for outings. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents advance directive where applicable are on file. Resident files reviewed (two rest home, two hospital, two dementia and two psycho-geriatric) had copies of the EPOA on file with the exception of one psycho-geriatric resident whose matters were still before the court. Admission agreements were on file with the exception of the aforementioned person and a new admission.</p> |

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| and give informed consent.  |    | Interviews with staff and families state they have input and are given choices. Care plans and 24 hours multidisciplinary care plans demonstrate resident choice as appropriate.  |
| Standard 1.1.11: Advocacy And Support<br>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.       | FA | 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. Advocacy and Code of Rights training was delivered by a HDC advocate in July 2020 attended by 37 staff. Local support groups offer advocacy services.  |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources<br>Consumers are able to maintain links with their family/whānau and their community. | FA | 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 volunteers visit the “homes”.   |
| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and upheld.                                 | FA | The service has a complaints policy that describes the management of the complaints process. There are concerns/complaint forms and information available at the entrance. Information about the complaints process is provided on admission. Staff interviewed could describe the process around reporting concerns/complaints. The operations manager is responsible for the management of complaints in consultation with the clinical manager and national clinical manager for care complaints. An on-line complaints register includes date of complaint, acknowledgment date, investigation, outcome and complainant response/resolution. There were three internal complaints in 2019 and two internal complaints for 2020 to date. Verbal complaints had been documented in the register. All concerns/complaints had been acknowledged and investigated within the HDC required timeframes. Letters of investigation and outcomes offer advocacy.<br><br>There have been no DHB or HDC complaints since last audit. |
| Standard 1.1.2: Consumer Rights During Service  | FA | The Code posters are displayed at the entrances of 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   |

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| <p>Delivery</p> <p>Consumers are informed of their rights.</p>   |           | <p>right to access advocacy services is identified and advocacy service leaflets are also available at the front entrances. On entry to the service, the operations manager or 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:<br/>Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>                           | <p>FA</p> | <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 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 (August 2020). During the visit, staff demonstrated knocking on doors prior to entering resident private areas. Interviews with family members identified that caregivers are always respectful and caring.</p> |
| <p>Standard 1.1.4:<br/>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> | <p>FA</p> | <p>There are policies and procedures for the provision of culturally safe care for Māori residents. On the day of the audit there were two residents who identified as Maori. Specific cultural needs are documented in the care plan and activity plan as sighted in the two Maori 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. The Māori Health plan is currently under review by an external cultural advisor. There are current guidelines for the provision of culturally safe care for Māori residents. Bi-cultural awareness training is included in the annual in-service education programmed and last occurred in September 2020. The education coordinator provides assistance and guidance for Maori residents as needed.</p>   |
| <p>Standard 1.1.6:<br/>Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive</p>   | <p>FA</p> | <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 church services are held. Staff receive training on cultural diversity.</p>   |

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| culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  |    |  |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | FA | <p>Discrimination, harassment, professional boundaries and expectations are clearly covered in the code of conduct that all staff are required to read and sign before commencing employment. Complaints regarding any alleged harassment, coercion, discrimination or abuse of any kind by a staff member are fully investigated and may be dealt with via both the complaint management and disciplinary processes. Discussions with the operations manager and a review of complaints identified no complaints of this nature. Staff have attended in-service on professional boundaries in September 2020.</p>   |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>   | CI | <p>An implemented quality improvement programme includes performance monitoring. A quality monitoring programme is implemented and this monitors contractual and standards compliance and the quality-of-service delivery. The service monitors its performance through resident/relatives' meetings, surveys, quality meetings, health and safety meetings, 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 hospital and medical 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. General practitioner visits for staff are partially subsidized 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. The service has been successful in applying best practice in dementia care resulting in a decrease of challenging behaviours.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>  | FA | <p>There is an open disclosure policy in place. A site-specific introduction unit booklet provides information on the secure dementia homes and psycho-geriatric 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. Six monthly family support</p>   |

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| <p>with consumers and provide an environment conducive to effective communication.</p>  |           | <p>meetings are held. Families are informed on service updates including the outcomes of surveys. Families are referred to Dementia Wellington support group. The HDC advocate visits residents at least annually and available at other times as needed.</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. Thirty-five incident/accident forms (including one near miss event) were reviewed for October 2020 and all forms evidenced family had been informed. Relatives interviewed, confirmed they are notified of any changes in their family member's health status.</p> <p>Care staff interviewed described ways of communicating with two residents with advanced dementia care who communicate in their primary language. This included using body language, sign language, use of pictures and they have learned basic phrases to communicate with the residents.</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 Lodge Lindale operates. Millvale Lodge Lindale provides rest home, hospital, dementia and psycho-geriatric level of care for up to 57 residents. On the day of audit there were 57 residents. There were six rest home residents (including one resident under long-term chronic health condition LT-CHC), 10 hospital level residents (including three residents under LT-CHC and one under the Mental Health Act), 27 dementia care and 14 psycho-geriatric level of care (including one resident under LT-CHC and one under the Mental Health Act). On the day of audit there were 38 residents under the ARCC, 12 residents under ARHSS, five under the LT-CHC and two residents under the Mental Health Act. There was one psycho-geriatric resident receiving level 2 DHB funding.</p> <p>DCNZ 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 creating a homely environment for residents, operating with openness, honesty and integrity, staff education, marketing and upgrade of IT systems. There is a resident focus on individualised care in small homes and specialist dementia understanding. There are four smaller home environments for residents at Millvale Lodge Lindale; Nikau unit -16 bed rest home and hospital, Kauri unit -12 bed dementia care home opened September 2019, Toe Toe unit -15 bed dementia care home and Tanika unit - 14 bed psychogeriatric home. The facility is located within a rural setting. One owner/director present during the audit stated there are plans to develop the paddocks for farm animals to graze further enhancing the rural outlook for residents.</p> <p>DCNZ has 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. The national clinical manager and national education coordinator were present during the audit. The site operations manager (non-clinical) has been in the role</p> |

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|   |    | <p>four years and reports to the operations management leader at head office. A clinical manager was appointed in November 2019. She has previous experience as an acting clinical manager at another DCNZ facility. The MOH was notified of the clinical managers appointment.</p> <p>The organisation holds an annual training day for all operations and clinical managers. The two-day conference for operations managers was held by zoom this year with managers at head office. The clinical manager completed a self-directed learning package specific to the role and has attended DCNZ clinical manager conference. The operations manager and clinical manager have both attended virtual learning on COVID-19 through the DHB and DCNZ. Both managers have been supported by the organisational team who visit the site regularly.</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 manager, the clinical nurse manager assumes the role with support from the DCNZ management team. In the absence of the clinical manger 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 Lodge Lindale 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; falls reduction, pressure injury prevention and management of acute and chronic pain is included in the 2020 quality plan.</p> <p>Progress with the quality and risk management programme is monitored through the monthly quality meetings held by skype with head office clinical and quality team. The operations manager 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. The operations manager 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/falls coordinator. There are monthly quality improvement/health and safety meetings, monthly infection committee meetings, home manager meetings, cooks' meetings, DT</p> |

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|  |           | <p>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 for all levels of care and includes policies related to medical services. The policy and document development and review group at head office review policies in consultation with relevant staff and distribute to the facilities. Staff are informed of any new/reviewed policies.</p> <p>The internal audit schedule for 2019 has been completed and 2020 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 a number of surveys including six-week post admission and respite care follow-up. Resident surveys for 2020 (12 responses) demonstrated satisfaction with the care, food and activities. There were 37 responses from the EPOA survey with an overall satisfaction rate of 88%. Relatives interviewed were very happy with the care provided stating staff were very approachable, welcoming, compassionate, genuine and 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 diversional therapist has been in the role of health and safety representative for two years and has completed on-line workplace health and safety and hazard management. The health and safety representative (interviewed) attends 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 last in October 2020. 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, falls coordinator input, 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</p> | <p>FA</p> | <p>The service documents and analyses incidents, accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Individual incident/accident reports are completed for each incident/accident with immediate action noted, RN assessment and any follow-up action</p>   |



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| <p>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>commenced.</p> <p>Thirty-five 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 &amp; safety meetings and RN/clinical meetings reflected a discussion of incidents/accidents and actions taken. Neurological observations are completed (as far as practical) for un-witnessed falls or head injury (actual or potential).</p> <p>Discussions with the operations manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been Section 31 notifications completed since the last audit. Notifications were two suspected deep tissue pressure injuries (January 2020 and February 2020) and one dementia care resident absconded (November 2020) and the wooden fence has been modified (sighted). There have been no outbreaks to report.</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>Seven staff files were reviewed (one clinical manager, one registered nurse, two caregivers, one diversional therapist, one home assistant and one cook). Job descriptions, reference checks and employment contracts were evident in all files reviewed. Performance appraisals were up-to-date. A copy of practising certificates was sighted for all registered nurses, and allied/medical staff.</p> <p>The service has in place a comprehensive orientation programme that provides new staff with role specific information for safe work practice. 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 seven files reviewed showed evidence of orientation to roles with competency packages completed. Competency packages are completed relevant to the role including medication administration, safe manual handling, restraint minimisation and safe practice, safe food handling, infection control, advocacy and abuse and neglect.</p> <p>The annual training programme for 2019 has been completed and the 2020 education schedule is being implemented with monthly education sessions that covers all required topics and includes clinical in-service. Staff can access on-site education sessions by zoom. External speakers/presenters are included in the training schedule such as pharmacist, physiotherapist, hospice nurses, fire safety and HDC advocate. Registered nurses have the opportunity to attend DHB study days.</p> <p>The national education coordinator is a registered psychiatric nurse and career force assessor. He provides regular staff training on the 'best friends' model of care, challenging behaviours, de-escalation and disengagement and has recently introduced Changing Minds (a changing approach to dementia care). All staff are required to complete Best Friends sessions 1 and 2. To date 63% of staff have completed both sessions.</p> <p>The education coordinator /career force assessor supports caregivers to complete the required aged care</p> |

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|   |           | <p>education and dementia unit standards for those staff working in the dementia and psycho-geriatric homes. There are 27 caregivers who work in the two dementia homes and psychogeriatric home. Twenty staff have completed dementia unit standards, two are in the process of completing the dementia unit standards and five staff are newly employed.</p> <p>There are nine registered nurses, including the clinical manager. Seven registered nurses and the clinical manager have completed interRAI training.</p>   |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | <p>FA</p> | <p>The staffing levels policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a registered nurse on duty in the home 24/7. The operations manager and the clinical manager work fulltime Monday to Friday. The operations manager is on-call for non-clinical concerns and the clinical manager provides 24 hours oncall for clinical matters.</p> <p>There is a RN on duty 24 hours in the rest home/hospital home who also oversees the two dementia homes. There is a RN on duty 24 hours in the psycho-geriatric home. The clinical manager is rostered one to two shifts per week in the psycho-geriatric home.</p> <p>Sufficient staff are rostered on to manage the care requirements of the residents. All caregivers with the exception of one caregiver (who works in the rest home/hospital only) are able to rotate through all the homes if required to provide cover however care staff and home assistants are allocated to a home to provide consistency of care for their residents that they know so well. Agency staff are not used. Care staff interviewed stated there are enough staff on duty to meet the needs of the residents. Relatives interviewed stated there were sufficient staff on duty when they visited</p> <p>Staffing is as follows:</p> <p>Nikau home (16 dual purpose beds) six rest home and 10 hospital level of care residents.</p> <p>Morning shift: three caregivers 7am-3pm</p> <p>Afternoon shift: three caregivers - one from 3pm-12 midnight, one from 3-10pm and one from 5-9pm</p> <p>Night shift: one caregiver (midnight to 8 am).</p> <p>There are diversional therapy hours from 10am – 1pm and from 1.30-4.30pm.</p> <p>There is a home assistant on duty from 8am-1pm and from 4.30-8pm.</p> <p>Kauri home (12 dementia care beds) 12 residents</p> <p>Morning shift: one caregiver from 7am-3pm and one from 7am-1pm (also does activities).</p> |

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|  |  | <p>Afternoon shift: two caregivers - one from 3pm-12 midnight and one from 4.30- 8pm</p> <p>Night shift: one home assistant (midnight to 8 am). Care is provided by the caregiver or RN on night shift in the rest home/hospital.</p> <p>There are diversional therapy hours from 1.30-4.30pm.</p> <p>Toe Toe home (15 dementia care beds) 15 residents</p> <p>Morning shift: two caregivers from 7am-3pm,</p> <p>Afternoon shift: two caregivers - one from 3pm-12 midnight and one from 3-9pm</p> <p>Night shift: one caregiver (midnight to 8 am). Assistant if required is provided by the caregiver or RN on night shift in the rest home/hospital.</p> <p>There are caregiver/DT hours from 10am-1pm and diversional therapy hours from 1.30-4.30pm</p> <p>There is a home assistant on duty from 7am-1pm and from 4.30-8pm.</p> <p>Tanika home (14 psychogeriatric beds) 14 residents</p> <p>Morning shift: two caregivers from 7am-3pm,</p> <p>Afternoon shift: two caregivers - one from 3pm-10pm and one from 3-9pm</p> <p>Night shift: RN on duty. Assistant if required is provided by the caregiver or RN on night shift in the rest home/hospital.</p> <p>There are diversional therapy hours from 1.30-4.30pm</p> <p>There is a home assistant on duty from 7am-1pm and from 4.30-8pm</p> <p>The role of the home assistant is to provide non-clinical support including laundry and cleaning duties. A home assistant (interviewed) described the morning shift duties including serving of breakfast and lunch, cleaning of kitchen, making beds, bed changes, mopping of rooms, waxing of carpet as needed, collecting dirty laundry and delivering to laundry and changing of rubbish bags. The afternoon home assistant folds laundry, serves dinner, vacuums bedrooms and communal areas, Distributes. Supper and cleans the kitchen. The home assistant in Toe Toe completes most of the laundry which is located in the service area outside of the Toe Toe home. Home assistants have completed food safety, chemical safety, health and safety and infection control training as well as other compulsory education.</p> <p>There is a cook on duty daily from 7am-5pm and a tea assistant from 4.45-6.45pm.</p> |
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| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>            | FA | <p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked in a secure area. Resident records are kept up to date and reflect residents' current overall health and care status. Active archives are appropriately stored and are accessible as required.</p> <p>Entries are legible, dated and signed by the relevant staff member including designation. Residents 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>There are pre-entry and admission procedures in place. Residents are assessed prior to entry by the psycho-geriatric team and needs assessment coordinators. The clinical manager liaises closely with the assessing teams to ensure the service can meet the assessed resident needs.</p> <p>The service has a well-presented information booklet for residents/families at entry. It is comprehensive and designed so it can be read with ease (spaced and larger print). Relatives interviewed stated they received sufficient information on the services provided and are appreciative of the staff support during the admission process.</p> <p>Of the resident files reviewed (two rest home, two hospital, two dementia and two psycho-geriatric), six had admission agreements that align with the Aged Related Residential Care (ARRC) agreement and The Aged related Hospital Specialised Services (ARHSS) agreement. One resident without an admission agreement was a new admission and the second was currently before the courts.</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>There is a discharge planning and transfer policy to guide staff in this process. Discussions with the service confirm that resident exit from the service is coordinated and planned and relevant people are informed. There is sufficient information to assure the continuity of resident's care through the completed internal transfer form, copy of relevant progress notes, copy of medication chart and doctor's notes. A staff member or family member (as appropriate) accompanies the resident to the hospital.</p>   |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and</p>  | FA | <p>The medication management system includes policy and procedures that follow recognised standards and guidelines for safe medicine management practice. Registered nurses and caregivers with medication competency administer medications. They have completed annual medication competencies and education. The facility uses robotic rolls delivered by the supplying pharmacy. The RN on duty reconciles the robotic</p>  |

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| <p>timely manner that complies with current legislative requirements and safe practice guidelines.</p>  |           | <p>packed medication against the medication chart and records this. An electronic medication documentation system is used.</p> <p>There was one resident who had been assessed as being able to self-medicate topical lotions and supplements. The standing orders meet legislative requirements. All medications are stored safely. There is a secure storage area where two medication trolleys are stored in the hospital/rest home area and a medication room in the psycho-geriatric wing where a further two trolleys are stored. It also contains a safe and medication fridge. The medication fridge temperature is monitored along with the room temperature in both areas.</p> <p>All 16 medication charts reviewed had photo identification and allergies noted. There were no gaps in the administration signing sheets. 'As required' medications had prescribed indications for use. The 16 medication charts had been reviewed by the GP three monthly.</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>All meals and baking are done on site by a full-time qualified cook five days per week and a second cook that covers the cook's days off.</p> <p>There is a verified food control plan in place issued 26 September 2019 which is due to expire in March 2021. The four-weekly organisational seasonal menu has been reviewed by a dietitian. There is a kitchen service manual located in the main kitchen, which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning and kitchen procedures. Kitchen staff have attended food safety and hygiene, chemical safety and relevant in-service training. Meals are transported in four hot boxes to kitchenettes in each wing where meals are served to residents.</p> <p>The cook receives a nutritional assessment for each new resident and is notified of any changes, special diets or weight loss. Pureed and normal diets are provided. Resident likes and dislikes are known, and alternative foods are offered. Cultural and spiritual needs are met. Weights are monitored monthly or more frequently if required. Residents assessed by the dietitian who require supplements received these and this is recorded in the resident's file. Special diets are catered for. The service also has access to a dietitian monthly for review of resident nutritional status and needs and notes are included in resident files.</p> <p>There is evidence that there are additional nutritious snacks available over 24-hours for all residents.</p> <p>There are adequate fluids sighted in the kitchenette fridges and supplement protein drinks are 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 are dated. The dry good store has all goods sealed and labelled and stored off the floor. Goods are rotated with the delivery of food items. The cook was observed wearing appropriate personal protective clothing. Chemicals are stored safely within the kitchen. There are safety data sheets available.</p> |

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|  |    | Residents and relatives interviewed were happy with the meals and snacks provided.   |
| <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 | The reason for declining service entry to residents is recorded should this occur and communicated to the resident (as appropriate)/family. The clinical manager reports that the referring agency would be advised when a resident is declined access to the service.   |
| <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>The information gathered at admission is used to develop care needs and supports to provide best care for the residents. RNs complete initial assessments within 24 hours of admission including risk assessment tools. Risk assessment tools are reviewed at least three-monthly. Behaviour assessments have been completed for all dementia and psycho-geriatric resident files reviewed. InterRAI assessments have been completed within required timeframes. The outcomes of InterRAI assessments including the risk assessments and behaviour assessments were reflected in the long-term care plans reviewed. The diversional therapist completes a comprehensive social assessment in consultation with the resident/family.</p> <p>All resident files reviewed included an individual assessment that included identifying diversional, motivation and recreational requirements.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>   | FA | <p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The long-term care plan is developed within three weeks of admission. The care plans are comprehensive and document interventions to meet the resident's needs. The outcomes of InterRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs. Care plans demonstrate allied health input into the resident's care and well-being. InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process. Eight family members confirm they are involved in the care planning process.</p> <p>Eight resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies.</p>                   |

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| <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>FA</p> | <p>The care being provided is consistent with the needs of residents as demonstrated in the review of the care plans and discussion with caregivers, registered nurses, diversional therapists, staff and management. The two residents interviewed (one rest home and one hospital) confirmed their needs were being met and they are well informed and involved in decisions. Families interviewed state their relative's 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>There were eighteen wounds. These included four surgical wounds, one moisture lesion, five skin tears, one cancerous lesion, one ulcer and six other wounds. Ten files reviewed evidenced all had wound assessments and evaluations have been completed. The wound nurse and GP have been involved as appropriate in the wound care and management of wounds. There was one hospital resident with a stage 2 facility acquired pressure injury. There were two psychogeriatric residents with facility acquired pressure injuries of the heel (one healing stage 3 and one stage 2). All have had GP, specialist wound, dietitian, physio input and two have had podiatrist input. Wound and continence management advice is available as needed and this could be described by the clinical manager and RNs interviewed and by entries in clinical notes. Continence assessments including a urinary and bowel continence assessment are completed on admission and reviewed three-monthly.</p> <p>Pain assessments are completed for all residents with identified pain and on pain relief. PAINAD assessments are completed for all residents unable to express pain. The effectiveness of pain relief is recorded in the electronic medication system.</p> <p>The dietitian visits monthly, completes any resident reviews due, and attends to any referrals received. The dietitian maintains progress notes in the integrated resident file.</p> <p>Behaviours that challenge were well identified through the assessment process in the residents' files reviewed. Twenty-four-hour multidisciplinary care plans describe the resident's usual signs of wellness, changes and triggers, interventions and de-escalation techniques (including activities), for the management of challenging behaviours. Behaviour monitoring was sighted in use for exacerbation of resident behaviours or new behaviours.</p> <p>Monitoring charts include blood pressure, pulse, temperature, food and fluids, weight, blood sugar levels and neurological observations.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>   | <p>FA</p> | <p>There are three qualified diversional therapists (DTs) The head DT has been employed with Dementia Care NZ for four years. The DTs between them work at least 96 hours per week covering seven days. Care staff on duty are involved in individual activities with the residents as observed on audit. There are resources available to staff for activities.</p> <p>There is an activity plan for each of the four units. The programme for the dementia and psychogeriatric</p>   |

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| <p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>                           |           | <p>residents is focused on individual and small group activities that are meaningful including household tasks, gardening, reminiscing and sensory activities such as massage and foot spas, baking, garden walks (extensive interesting areas in which to walk), games, flower arranging, music, singalongs and movies. The rest home/hospital programme reflects resident interests, abilities and skills and includes entertainment, exercises, craft activities, happy hour, news and views. Residents from the dementia units are invited to attend entertainment held in the rest home/hospital 'home' with adequate supervision. There is allocated one-on-one time for residents who choose not to or are unable to participate in group activities.</p> <p>There are volunteers involved in the programme with spiritual services weekly, weekly pet therapy and piano playing. Entertainment is scheduled regularly along with van outings twice weekly. The service has a wheelchair van.</p> <p>Activity assessments, activity plan, 24-hour MDT care plan, progress notes and attendance charts are maintained. Resident and family meetings are held monthly. Resident files reviewed identified that the individual activity plan is reviewed at the same time as the care plan review.</p> <p>A comprehensive social history is completed on or soon after admission and information gathered from the relative (and resident as able) is included in the activity care plan. A 24-hour MDT care plan is reviewed at least six-monthly.</p> <p>Caregivers are 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 four lounges simultaneously. Resident and relative surveys identified satisfaction with the activities offered.</p> |
| <p>Standard 1.3.8: Evaluation<br/>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <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. The family are invited to the six-monthly MDT reviews. Other health professionals are involved as appropriate, such as the physiotherapist and dietitian. Short-term care plans are reviewed as required and resolved or if an ongoing problem added to the long-term care plan. There is at least a three-monthly review by the medical practitioner of the resident. 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>FA</p> | <p>The service facilitates access to other services (medical - including dental, and non-medical) and where access occurs, referral documentation is maintained. Family/EPOA are involved as appropriate when referral to another service occurs. The service liaises closely with the need's assessment team. Currently there are no examples where a resident's condition has changed and required reassessment to a different level of care.</p>  |



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| 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>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>The service has in place, management of waste and hazardous materials policy and relevant procedures to support the safe disposal of waste and hazardous substances. These include but are not limited to: a) sharps procedure, b) cleaning/chemicals procedures and c) exposure to blood or other body fluid contamination policy. Training is provided to the staff around safe management, as part of the annual training plan. Chemicals are labelled and there is appropriate protective equipment and clothing for staff. There are sluice rooms for the disposal of soiled water or waste.</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 has an equipment preventative maintenance programme in place to ensure that buildings, plant, and equipment are maintained appropriately. In lieu of a current building warrant of fitness (unavailable under COVID-19 restrictions) the building has a building systems status report which expires on 16 May 2021. Electrical equipment has been tested and tagged (June 2020). 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 are ramps to the outsides and the paths are maintained. The four homes each have homely, open dining/lounge areas and allow for the use of mobility equipment. Each home has outside areas that include seating and shade around the facility. The outdoor areas for the secure environments are safely accessed with walking pathways and gardens.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided</p>  | FA | <p>There are adequate numbers of toilets and showers with access to a hand basin and paper towels. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Communal toilets and showers are well signed and identifiable. Forty-five, of the 57 bedrooms are ensuited. There are also staff and visitor amenities. Mobility aids can be managed in communal bathrooms.</p>  |

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| <p>with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>                            |    |   |
| <p>Standard 1.4.4: Personal Space/Bed Areas<br/>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>  | FA | <p>All residents' rooms are single and of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids and hoists if required. Residents and families are encouraged to personalise the rooms as observed on the day of audit.</p>  |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining<br/>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | FA | <p>There are four lounge/dining rooms within the facility, they are well proportioned and can accommodate the lounge furniture and dining tables. Activities can occur in the lounges and/or the dining area. There is adequate space to allow maximum freedom of movement while promoting safety for those that walk.</p>  |
| <p>Standard 1.4.6: Cleaning And Laundry Services<br/>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service</p>  | FA | <p>Home assistants on the morning and afternoon shifts carry out cleaning and laundry duties. The service has in place policies and procedures for effective management of laundry and cleaning practices. This included (but is not limited to) collection of soiled laundry, linen processing and transporting. Laundry and cleaning processes are monitored for effectiveness. There is a designated area for the storage of cleaning and laundry chemicals. Families interviewed were satisfied with the laundry and cleaning services.</p> |

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| is being provided.   |        |  |
| <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>  | PA Low | <p>There are emergency and disaster plans in place to guide staff in managing emergencies and disasters. Emergency management and self-directed learning packages are completed as part of orientation and ongoing education plan. All RNs and DTs have a current first aid certificates providing staff on duty 24 hours with a first aid certificate. The facility has an approved fire evacuation plan for the existing building however the fire service has not yet approved the fire evacuation scheme for the new 12 bed dementia care home (Kauri). Fire drills occur six-monthly. In the event of a power failure, emergency lighting, battery backup for call bells and alternative cooking is available. There are sufficient food supplies for at least three days and an emergency menu is available. The service is on a priority hire list for a generator as required. There are civil defence supplies (checked monthly) that are readily accessible and include torches, batteries and radios. An external 10,000 litre tank of water provides at least 20 litres water per person for 7 days. Call bells are evident in resident's rooms, lounge areas and toilets/bathrooms. There are separate bedroom sockets for sensor mats which sound differently from the call bells. The facility is secured at night with external sensor lighting in place. All external doors are alarmed. Entry and exit to the dementia and psychogeriatric homes are secure.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA     | <p>General living areas and resident rooms are centrally heated and there is good ventilation. Residents have access to natural light in their rooms and communal areas are light.</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</p>  | FA     | <p>The Infection Control (IC) programme and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The infection programme is reviewed yearly by head office clinical personnel, the infection control coordinators and the national clinical manager. The service infection control goals are reviewed quarterly by the infection control committee. Goals for 2020 include increasing the uptake of staff influenza vaccinations, reducing skin infections and reducing urinary tract infections.</p> <p>There is a job description for the IC nurse (registered nurse) and clearly defined guidelines and responsibilities for the infection control committee. The infection control committee meet monthly and include the clinical manager, RNs, DT and kitchen representation. The minutes are posted on the staff notice board.</p> <p>Visitors are asked not to visit when unwell. There are hand sanitises placed throughout the facility. Residents</p>  |

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| scope of the service.   |    | and staff are offered the influenza vaccine. Visitors and contractors complete a health declaration before entering the facility.   |
| Standard 3.2:<br>Implementing the infection control programme<br><br>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.   | FA | The infection control (IC) committee meets monthly and is made up of a cross section of staff from across the service. The service also has access to IC team at the DHB, Public Health and GPs. There is expertise at head office with the clinical advisor and national clinical manager readily available for advice and support. The clinical manager is completing a course in advanced nursing practice – infection control. An independent microbiologist is readily available for advice and education. The infection control coordinator has been in the role since April 2020 and has completed infection control on-line training on pandemic outbreaks and is currently completing the Sepsis module. He has also attended a zoom session on Covid-19 preparedness with the DHB infection control team.<br><br>There are outbreak management kits and plentiful supplies of hand sanitizer and personal protective equipment. |
| Standard 3.3: Policies and procedures<br><br>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. | FA | There are infection control policies and procedures appropriate to the size and complexity of the service. Policies and procedures are reviewed two yearly by the policy development and review group in consultation with infection control coordinators. Staff are notified of any reviews/updates at the staff meetings. Additional policies related to COVID-19 have been developed and added including DCNZ pandemic plan, pandemic planning policy, DCNZ COVID-19 policy and COVID-19 outbreak management plan.   |
| Standard 3.4: Education<br><br>The organisation provides relevant education on  | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. All staff receive infection control education as part of the orientation programme. Staff are required to read policies and complete the infection control self-directed learning package and competencies. Staff attend   |

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| infection control to all service providers, support staff, and consumers.   |    | annual infection control education.  |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | CI | <p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator 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, RN 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. The clinical manager provides a monthly clinical bulletin which includes infection control data, trends and analysis of infections.</p> <p>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 and monitor the use of antibiotics.</p> <p>Benchmarking occurs against other Dementia Care New Zealand facilities. There have been no outbreaks.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  | CI | <p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes restraint procedures. The restraint coordinator is a registered nurse. Interviews with caregivers and nursing staff confirm their understanding of restraints and enablers. There were no residents with restraint or using enablers on the day of audit. Staff complete restraint competencies and attend education and training in restraint minimisation and safe practice.</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)                                |
|--|-------------------|--|---|---|
| Criterion 1.4.7.3<br>Where required by legislation there is an approved evacuation plan. | PA Low            | Building plans (including fire walls and fire separations) were approved in building consents prior to construction of the 12-bed dementia home. All staff received an orientation to the new home and attended fire safety in-service prior to occupancy. A fire drill was completed soon after occupancy. A building warrant of fitness was obtained. One owner/director (interviewed) has engaged the services of a professional building engineer who has submitted the required information to the fire service 5 November 2020 (correspondence sighted). To date the provider has not received a response from the fire service. | The fire service has not yet approved the fire evacuation scheme for the new 12 bed dementia care home (Kauri). Detailed information regarding fire separations has been set to the Fire Service (email sighted) and the provider is awaiting a response. | Ensure the Fire Service approves the fire evacuation scheme for the new build.<br><br>90 days |

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

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

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

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

| Criterion with desired outcome   | Attainment Rating | Audit Evidence  | Audit Finding  |
|--|-------------------|---|--|
| <p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p> | CI                | <p>The team at Lindale identified a slight increase in the challenging behaviour rates from 5.92 in 2018 to 6.14 in 2019. A quality improvement plan was developed that has been successful in enhancing care staff skills and knowledge around</p> | <p>The service identified reducing distressing behaviours was ongoing and can originate in a small cohort of residents for example newly admitted residents and those with increasing cognitive impairment where previously behaviours had not been present. While behavioural management strategies were already embedded the team wanted to set goals around enhanced practice utilising the skills of the DCNZ National mental health nurse, nurse practitioners, GPs, medical specialists at Lindale staff. Strategies identified included a focus on medication reviews, medical reviews, reassessments and identification of triggers and new triggers, improved RN observations and more detailed documentation and reporting to avoid exacerbation of behaviours. Oversight was provided by the clinical manager and there was close collaboration with the RNs, care staff and families were encouraged where possible to contribute and inform staff resulting in increased relationship opportunities for families. Additional case management support for complex resident behaviours is provided by the national mental health nurse who reports directly to the directors. The service provides training on “Best Friends Approach to Dementia Care”. This approach treats and respects residents as their “best friends”, getting to know them and “walking through their journey together”. A new training session called “Changing Minds” has been introduced 2020 and focuses on the changing approaches to dementia care focusing on communication and the concept that changes in behaviour are normal responses to an environment or situation. The reduction of challenging behaviours from 6.14 in 2019 to 4.43 for 2020 to date has had direct positive effects on the</p> |

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|   |    | behaviour management in the dementia and psycho-geriatric homes. The challenging behaviour incidents have reduced to 4.43 for 2020 to date.   | resident's wellbeing, their families. other residents and staff. Families report more confidence around staff ability to manage difficult behaviours/events. Relative interviews on the days of audit confirmed their trust and confidence in staff to deescalate challenging situations well. A staff survey evidenced staff felt more knowledgeable, confident and skilful in how they respond to changing behaviour. The 2020 self-rating of 9.5 out of 10 had increased in comparison to 7.75 in 2019.  |
| Criterion 3.5.7<br>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | One of the infection control goals for 2020 was to increase the percentage of staff receiving influenza vaccinations above 90% to protect their vulnerable residents from influenza like illnesses. Staff vaccinations increased to 100% in 2019 compared with 65.7% in 2018. The percentage of staff receiving influenza vaccinations has remained high in 2020 and the rate of influenza- | An action plan was developed to reduce influenza-like illnesses of its vulnerable residents and increase the percentage of staff receiving influenza vaccinations. This included additional education around hand hygiene, infection control self-directed learning packages, outbreak management (by zoom), personal protective equipment, influenza and waste management. Staff completed competences for hand washing and personal protective equipment. In April 2020 92% of staff received an influenza vaccine. There is a monthly analysis of chest infections, trends and analysis which is benchmarked at head office. The service is under the benchmark level for chest infections with .388 per 1000 bed days in 2019 and trending downwards to .31 per 1000 bed days in 2020. The service has been successful in protecting its residents by the reduction of morbidity and mortality resulting from influenza-like illnesses. |



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|  |    | like illnesses remain below the benchmark rates.   |   |
| <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>The service has been restraint free for eight months. Restraint use is the last resort.</p> | <p>The service focuses on a “best friends” approach to residents with dementia, advanced dementia and challenging behaviours. Staff are well educated on de-escalation and disengagement and noticing the signs of delirium. Each resident has a 24-hour MDT plan with input from RNs, caregivers and the DTs that describes the resident’s usual wellness, sign of un-wellness including triggers for behaviours. The education plan has recently introduced “changing minds”, an approach to changes in dementia care. The restraint coordinator and clinical manage and RNs meet monthly or earlier to discuss any concerns. There is a monthly resident event analysis meeting where individual residents with challenging behaviours are discussed and alternative strategies developed including activities. The national mental health nurse provides support to the Lindale team on management of complex behaviours (link CI 1.1.8.1). On the days of audit there was a calm atmosphere in the homes and the staff seen to be interacting well with the residents, either in group or individual activities. Staff interviewed state they know the residents very well and any behaviour or falls concerns were addressed promptly by the RNs and action plans put in place including GP reviews and psycho-geriatric team involvement. The service has remained restraint free for eight months with the last restraint (arm restraint) in February 2020 and previously bedrails restraint in 2018. There were no restraints in 2019.</p> |

End of the report.