

Kingswood Healthcare Matamata Limited - Kingswood Rest Home

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Kingswood Healthcare Matamata Limited

Premises audited: Kingswood Rest home

Services audited: Dementia care

Dates of audit: Start date: 6 July 2015 End date: 7 July 2015

Proposed changes to current services (if any): None

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

Kingswood Matamata is an aged care facility that is part of the Kingswood Healthcare group of aged care facilities. The service provides rest home specialist secure dementia level of care for up to 24 residents.

A full certification audit was conducted against the Health and Disability Services Standards and the services' funding contract with the Waikato District Health Board. The audit process included an offsite review of organisational policies. The onsite audit included the review of documentation and residents' files, observations and interviews. Interviews were conducted with management, staff, families/whanau and a nurse practitioner to verify the documented evidence. There were informal interviews and feedback from residents.

The service is meeting the requirements of all the standards and no systemic issues are identified at this audit. The service received ratings to demonstrate continuous quality improvements in their education programme, reduction of incidents and accidents, care interventions and reduction of infections.

Consumer rights

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



Standards applicable to this service fully attained.

The service has processes in place that demonstrate their commitment to ensuring residents' rights are respected during service delivery. Staff knowledge and understanding of residents' rights is embedded into everyday practice as observed during the audit. Residents and family are informed of their rights as part of the admission process, with information on the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights) and advocacy services clearly displayed and accessible throughout the facility.

Resident and family interviewed confirmed their satisfaction with the staff and provision of services. Residents are provided with care and services that maximises each person's independence and reflects the residents' and their families' wishes. Policies, procedures and processes are in place to keep residents safe and ensure they are not subject to abuse, neglect and discrimination.

Residents who identify as Maori and from other cultural groups have their needs met in a manner that respects and acknowledges their individual and cultural values and beliefs.

Residents receive services of an appropriate standard for dementia level of care. The service provides an environment that encourages good practice.

Staff communicate effectively with residents and the right to full and frank information and open disclosure was demonstrated. The service demonstrates that written consent is obtained where required. The residents are able to maintain links with their family and the community. Residents have access to visitors of their choice.

The complaints process is easy to access and meets the rights of the residents and their family/whanau. There are no open complaints at the time of audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation's mission statement and vision have been identified in the business and strategic plan. The service incorporates the resident centred approach of the 'Spark of Life' into their philosophy and service delivery. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents' needs. The management team regularly review the business, risk and quality plans.

The quality and risk system and processes support safe service delivery. Corrective action planning is implemented to manage any areas of concern or deficits identified, with documentation showing the evaluation and follow up of the corrective actions. The quality management system included an internal audit process, complaints management, resident and relative satisfaction surveys and incident/accident and infection control data collection. Quality and risk management activities and results are shared among staff. One of the strengths of the service is the continuous quality improvement project they have conducted into reducing falls and resident related injuries.

The education programme and ongoing implementation of the Spark of Life approach to care is another strength of the service, with these projects gaining positive outcomes in resident, family and staff satisfaction.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

Records are securely secured. There is no information of a private nature on public display.

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.

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

Policies and procedures clearly explain the entry criteria for the service and actions that would be taken if any resident were to be declined entry to the service. At the time of audit the service has not declined entry where the resident has an appropriate assessment for dementia level of care and a bed is available. If residents' needs exceed the level of care available, reassessment is conducted and the resident is transferred to a service that better meets their needs (eg, hospital level of care).

The service meets the requirements and timeframes for assessment, care plan development, review, evaluation and the provision of care. The residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcomes. The evaluation of care is conducted at least six monthly, with this documenting the resident's response to interventions and progress towards meeting goals.

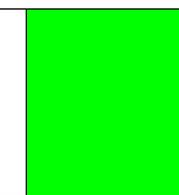
Residents are supported to access and/or be referred to other health and disability services, as appropriate, to meet their needs. Transition, exit, discharge or transfer from the service is planned and coordinated to minimise risks. Particular strengths, resulting in continuous improvement, are the projects related to reduction in falls, medications and challenging behaviours, all of which have been evaluated with positive outcomes.

The service provides planned activities to ensure what is offered is meaningful to the residents and allows them to maintain or improve their strengths, skills and interests. The service has links with community organisations for activities both onsite and offsite.

The observed medicine administration process is undertaken in a safe and timely manner that complies with current legislation and safe practice guidelines. Staff who undertake medicine administration hold appropriate competencies.

Residents are provided with food, fluid and nutritional services that have been reviewed as being suitable to meet the nutritional needs of the older person. Residents receive additional or modified nutritional requirements, special diets and food that takes into account the resident's likes and dislikes.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The service provides a safe and secure environment for residents living with dementia. The internal and external garden areas are designed for residents to wander freely.

There are documented emergency management response processes which were understood and implemented by staff. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness. There is an approved evacuation scheme and ongoing maintenance plans.

There are appropriate cleaning and laundry services.

The facility provides furnishings and equipment that is appropriate to the level of care provided and is regularly maintained. There are adequate toilet, bathing and hand washing facilities. Designated lounge and dining areas meet residents' relaxation, activity and dining needs.

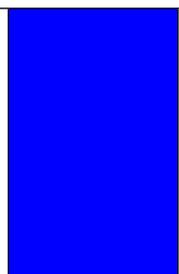
The building is suitably heated, cooled and ventilated. The outdoor areas, gardens and verandas provide suitable furnishings and shade for residents' use.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The environment is restraint free. Where an enabler is used, this is voluntary and the least restrictive option. There is one enabler in use. Staff demonstrated knowledge on restraint minimisation, enabler use and maintain the freedom of movement of the residents.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		All standards applicable to this service fully attained with some standards exceeded.
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Infection prevention and control systems are implemented by the service to minimise risk of infections to residents, staff and visitors. The delegation of infection control matters is clearly documented. The infection prevention and control programme is reviewed at least annually. There are adequate resources to implement the infection control programme with the infection data reviewed at the staff meeting to ensure all required corrective actions are followed up. The service's policies and procedures comply with relevant legislation and current accepted good practice. The service provides education on infection control to all staff, and when relevant, residents and family.

There is a monthly collection of surveillance data for infections. The surveillance data is collated and analysed, with results

communicated to staff. Documentation identifies that if trends are identified the service implements actions to reduce the prevalence of infections. The service has clear procedures to deal with outbreaks.

A continuous improvement rating reflects improvements made as a result of a project to reduce infection rates.

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	2	43	0	0	0	0	0
Criteria	4	89	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>As observed on the days of audit staff incorporate aspects of consumer rights into everyday practice. They knock on doors before entering residents' bedrooms, use residents' preferred names when speaking to them and ask permission prior to undertaking care. Staff interviewed confirmed they respect the resident's right to refuse care or interventions. The interviews with residents and family members confirmed they or their family member receives services that respect their rights. The families commented that one of the strengths of the service is in the manner that all staff respect the residents as individuals. The nurse practitioner (NP) interviewed had no concerns about breaches of residents' rights.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>Signed consent forms are sighted in residents' files reviewed. Informed consent is inclusive of the admission agreement and is discussed prior to signing as confirmed during interview with family members. The residents' files reviewed have correctly signed advance directives or an advance care plan identifying the resident's chosen wishes related to resuscitation status and end of life care. The clinical staff demonstrated their understanding of acting on valid advance directives.</p>

give informed consent.		
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The residents' files reviewed and interviews with family confirmed that the service actively encourages residents to participate fully in determining how their health and welfare is managed. Family are encouraged to involve themselves as advocates and an advocate from the Nationwide Health and Disability Advocacy Service visits the service regularly. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the client admission information and along with local advocacy services information and contact details are readily available at the entrance to the facility which family members confirmed their awareness of where to locate the information.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interviews with family confirmed the residents have access to visitors of their choice. Residents are encouraged and supported to maintain and access community services along with friends and family. Documentation sighted in residents' files identified that regular community outings occur and the frequency that residents go out with friends and family and the community services who visit the facility. One resident has weekly outings with a kaumatua. Some community outings include weekly coffee club group, shopping trips, regular church services, school visits and entertainment. Residents are welcome to have their own spiritual advisor visit or to attended services in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints register and sample of complaints for 2015 evidences that complaints are managed within time frames of Right 10 of the Code. The complaints register records one complaint to date for 2015. Complaints forms are available at the entrance, with information given on the complaints process as part of the admission process. Families report they are encouraged to provide feedback or make a complaint. The complaints processes are audited as part of the quality internal auditing programme.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Opportunities are provided for explanations, discussion, and clarification about the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) with family as part of the admission process. As observed, contact information and brochures for the Nationwide Health and Disability Advocacy Service are clearly displayed at the entrance to the facility and available to residents and visitors. Families reported they are informed of their rights and that staff always respect all aspects of their rights.
Standard 1.1.3:	FA	The environment allows residents' physical, visual, auditory and personal privacy. All rooms are single or double

<p>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>occupancy (with agreement from the family) to maintain privacy. Resident's needs, values, beliefs including culture and religion, are assessed as part of the admission process and appropriate interventions are put in place to meet recognised needs. This is confirmed in residents' files reviewed which identify interventions put in place match identified needs.</p> <p>As observed at the time of audit services are provided in a manner that maximises each resident's independence and allows choices to be respected. The family interviewed reported that they are treated with respect and that residents receive services in a manner that has regard for their dignity, privacy, and independence. Residents are kept safe and are not subjected to, or at risk of, abuse and/or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Māori residents have access to appropriate services, and barriers to access within the control of the organisation are identified and eliminated. The manager reported there are no barriers to Māori accessing the service. There are a number of Māori residents and staff at the service. The importance of whanau and their involvement with the resident is recognised and supported by policy and understood by staff as confirmed during interviews with care staff. Staff verbalised their knowledge of providing care that is commensurate with the cultural, spiritual and individual beliefs of residents. The file of a resident, who identified as Māori, recorded the resident's iwi and described the importance of whanau.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>There are general guidelines to assist staff in the assessment and delivery of services that will meet residents' cultural and spiritual needs. This includes the use of interpreter services as required. Residents receive services that take into account their cultural and individual values and beliefs. Policy identified that the resident's choice of representative is accepted by the service.</p> <p>Interviews with family members confirmed they are consulted on their relative's individual values and beliefs and that care is planned and delivered to meet individual resident needs. This covers social, spiritual, cultural and recreational needs. Family are involved in the development and review of the care plan, as sighted in residents' files reviewed.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff files reviewed identify that staff sign a code of conduct that identified that the staff maintained professional boundaries and refrain from acts or behaviours which could be deemed as discriminatory. Interviews with staff, the nurse practitioner (NP), and family members confirmed they have no concerns related to discrimination, coercion, harassment, sexual, financial or any other form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There is regular in-service education and staff access external education that is focused on best practice, with all educational material sighted showing evidence of being relevant to current best practice standards. Interviews with staff confirmed that the environment in which they work encourages good practice. All staff are supported by management and have access to evidence based policies and procedures and appropriate ongoing education. Interviews with family and the NP confirmed their high level of satisfaction with all care delivery and staff attitudes. This is further supported by the results of the recent resident satisfaction survey.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policy related to open disclosure is implemented by the service. Interviews with family members confirmed they are kept informed of the resident's status, including any adverse events, incidents or concerns staff may have. Family communication is clearly documented in the residents' files reviewed, on incident and accident forms sighted and in the staff communication book. The family, residents and NP interviewed report that communication is strength of the service.</p> <p>Wherever necessary and reasonably practicable, interpreter services are provided. Contact details for the interpreter service are clearly set out in resident admission information and in policy. At the time of audit there are no residents who require interpreter services.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the</p>	<p>FA</p>	<p>Services are planned to meet the needs of residents living with a diagnosis of dementia and requiring a specialised secure environment. The service provides care for up to 25 residents. The service provides long term care and short term respite care. The service is part of the Kingswood Healthcare group that has another two aged care services in Morrinsville and Cambridge.</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and reviewed in a two year cycle. The business and strategic plan for 2013-2015 includes the Spark of Life, resident centred approach to dementia care, which is incorporated into the organisational goals, vision and philosophy. The directors and general manager are responsible for ensuring the overall financial welfare of the service delivery. The general</p>

needs of consumers.		<p>manager reports to the directors formally on a monthly basis, but more often informally. There is a monthly report at management meetings, with a full report on all residents, staff, health and safety, infection control, occupancy and any other matters requiring attention.</p> <p>The clinical management of the service is conducted by the clinical manager who oversees this and the Morrinsville service. There is also a registered nurse (RN) and a nurse practitioner that support the clinical management of the Matamata service. The clinical manager's job description outlines their role and responsibilities for the clinical management of the service. The general manager reports confidence in the clinical manager's abilities for the management of the clinical aspects of service delivery. The clinical manager and general manager have both attended over eight hours education related to the management of aged care services, their responsibilities to provide aged care services with the DHB and they attend other clinical education related to dementia and aged care. The clinical manager has completed their interRAI training.</p> <p>The family's interviewed and satisfaction surveys report and record satisfaction with the quality of care and services at Kingwood Matamata.</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>The administration officer/caregiver takes on the management role in temporary absences, with support from the RN and nurse practitioner. The administration officer attends ongoing education on the management of aged care services. The administration officer and RN demonstrated knowledge of their responsibilities during temporary absences of the clinical manager.</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</p>	FA	<p>The organisational policies and procedures are developed by an aged care consultant and have been personalised to the service. The policies are updated and reviewed at least two yearly or when there are changes to legislation of best practice. The policies were last reviewed in 2014. The policies include the organisational and RN responsibilities for the implementing and use of interRAI. Only current versions of documents are available to staff. Staff sign to say that they have read the current policies.</p> <p>The risk and quality management systems cover the key components of service delivery. There is an audit scheduled which is adhered to. Staff demonstrate knowledge of the quality and risk management systems and report that they are fed back the results and implement corrective actions as required. Staff report that the Spark of</p>

<p>continuous quality improvement principles.</p>		<p>Life approach to care is integrated in their delivery of care and services.</p> <p>Quality data is collected through internal audits, staff and family satisfaction surveys, incidents and accidents and infection surveillance data. Where there are shortfalls noted in the internal audits action plans are implemented. The results are fed back to staff through the staff meeting, memos and staff handover. The weekly management meeting discusses audit results and any areas of concern. The management meeting and quality/staff meetings are also used to measure achievement against the quality and risk management plan.</p> <p>Corrective action planning includes the area that needs improving, how it is to be implemented, who is responsible and when completed. There is some benchmarking of results with the other Kingswood service in Morrinsville. The corrective action form includes follow up review of the actions implemented to ensure these have been effective.</p> <p>The family satisfaction survey identifies positive feedback about the care, services and environment at Kingswood Matamata. Where any dissatisfaction was expressed, the service implemented corrective actions to address this. The surveys have been compared with previous years and record increased satisfaction from families and staff.</p> <p>Actual and potential hazards and risks are recorded in the hazard register. The hazards include clinical and business risks. There are also hazard identified forms for newly identified issues. The hazard register records a description of the hazard, possible remedies, actions taken and if the actions taken were effective in addressing the hazard or reducing the risk. Hazards that can now be eliminated have ongoing monitoring.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff and management understand their obligations in reporting serious harm. There have been no incidents that have required reporting to the required authorities. Staff understand when they are required to complete an accident/incident form.</p> <p>The service has conducted a quality improvement project into the accident/incident reporting system to reduce injuries to residents (refer to criterion 1.2.4.3).</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>All staff and contractors who require an annual practising certificate (APC) have these validated at employment and annually. A register is maintained of when APC and competency assessments are due. Copies of APCs are</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>sighted for all staff who require them.</p> <p>Staff files evidence appropriate processes are implemented for the recruitment, employment and orientation of new staff. All new staff undertake an orientation that includes the essential components of service delivery and health and safety, All staff are required to complete a Spark of Life course and are required to demonstrate the philosophies of the resident centred care, as well as the Kingswood Healthcare's philosophy.</p> <p>All staff who have worked at the service for longer than six months have completed the dementia unit standards, with newer staff enrolled in the programme and on target to complete within six months to one year of employment. The RNs have completed their required interRAI training and demonstrated knowledge on the use of this tool to assess resident's needs to inform the care planning process.</p> <p>The service has conducted a quality improvement project into the staff and family education (refer to criterion 1.2.7.5). The ongoing education programme meets contractual requirements for the delivery of care to residents living with a cognitive impairment. Attendance records are maintained to evidence the implementation of the ongoing education programme. Staff report they have access to both external and in-service education. The in-service education includes training specific to dementia care.</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>There is clearly documented policy on staffing levels and skill mix to meet the needs of residents requiring secure dementia level of care. There is a RN on duty four days a week. The on call RN roster is shared with the RN and clinical manager (RN). There is at least two caregivers on duty each shift and there is an additional caregiver on duty at the 'sun downing' times. The service conducted a project on accidents and incidents (refer to criterion 1.2.4.3) in which they implemented this extra caregiver at high risk times, which has resulted in reduction of challenging behaviours, falls and injuries.</p> <p>There is at least one staff member on duty each shift who has current first aid qualifications. There are appropriate staffing level for activities, cook, cleaning, administration and maintenance workers. Staff confirmed they have adequate time to do their required work and all staff assist in implementing meaningful activities for the residents throughout their shifts.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential,</p>	<p>FA</p>	<p>The residents' files reviewed identify that information is managed in an accurate and timely manner. Health information is kept in secure areas at the nurses' station and is not accessible or observable to the public. Electronic records are secured and password protected. Entries into the progress notes are made each shift which records the staff member's name and designation. The current progress notes are in a separate folder from the resident's main file, although these files demonstrate integration of the records with the progress notes then filed in the main clinical folder. The residents' files reviewed evidence that all records pertaining to individual residents are integrated. The service uses a mix of electronic and paper based records, with the relevant electronic</p>

and accessible when required.		<p>assessment/care plans printed and a copy placed in the resident's hard copy folder. Hard copy records are stored on site and there is electronic archiving and back up for the electronic records.</p> <p>All residents' files reviewed showed evidence of completed interRAI assessments.</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>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to potential residents, their family of choice where appropriate, local communities, and referral agencies. The service offers secure dementia level of care. The service has a pre-entry form which identifies the residents required level of care. The vacancy and entry requirements are updated daily on the Eldernet website. There is a new information booklet which covers all information required to make an informed choice.</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>Risks are identified prior to planned discharges, as was confirmed by interview with the RN. There is open communication between the service and family related to all aspects of care, including exit, discharge or transfer. If there are any specific requests or concerns that the family want discussed, these are noted on the transfer form. The specific discharge form used covers all general and specific care provision and a summary of the current care plan showing all aspects of care provision and intervention requirements and is sent with the resident as appropriate. Other information sent with the resident includes a copy of their admission profile page, medication profile which identifies known allergies, a summary of medical notes and a copy of any advance directives that are in place.</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 medicines are dispensed by the pharmacy in a pre-packed system. The packs are delivered monthly, with any changes that are made by the GP delivered the same day as the change. Medicines that are not packed (eg, liquid medicines) are individually supplied for each resident. The medication packs and other non-packed medicines are checked for accuracy against the prescription by the RN when they are administered. The GP conducts medicine reconciliation on admission to the service and at a minimum of three monthly which he signs for on the resident medication chart. The GP conducts a review of the resident's medicines at a minimum of three monthly which the GP signs for on the resident's medication chart. At the time of audit, the service does not use standing orders.</p> <p>The medicines are stored in a locked cupboard. The medicine fridge is monitored for temperature, with the weekly temperature recordings complying with guidelines. Sample signature verification is recorded for all staff who administers medicines.</p>

		<p>The medicine charts reviewed are compliant with legislative requirements. All prescriptions are computer generated by the pharmacy and they allow a safe medication administration process to be undertaken by staff. The prescriptions are legible, record the name, dose, route, strength and times for administration. Short term medication has a start and stop date. All the medicine charts sighted identify residents' allergies recorded.</p> <p>The RN and some designated caregivers are responsible for medicine administration at the service. All staff who administers medicines have a current medication competency.</p> <p>There are no residents self-administering at the time of the audit. The facility does not use standing orders and currently there are no controlled drugs at the facility.</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>Since the last audit the kitchen service has been brought in house. This has been successful with staff being retained and more personal menu features for the residents. The menu is reviewed by a qualified dietician against the national guidelines for older people living in aged care and the Heart Foundation guidelines for the older person. The menu is a six week rotational menu with seasonal variations (eg, summer, autumn, spring and winter menu).</p> <p>Every resident has a nutritional assessment review on entry to the service (and reviewed when indicated), and all residents are routinely weighed at least monthly. The cook also asks the residents what they would like for meals. There is a monthly kitchen audit that includes feedback on the quality of the meals. Informal interviews with residents confirmed they are satisfied with the food service and that their likes and dislikes are catered for. They report that if there is something they do not like, there are always alternatives offered.</p> <p>Residents with additional or modified nutritional needs or specific diets have these needs met. The menu clearly records the choices for residents on modified diets. The diabetic or special diets are clearly specified.</p> <p>There is an ongoing cleaning programme in place for the kitchen and all aspects of food procurement, production, preparation, transportation, delivery and disposal are complied with to meet current legislation and guidelines. When food is decanted from its original packaging, the food is stored in food safe containers, labelled and dated. Any food that is returned to the fridge is covered, labelled and dated.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p>	<p>FA</p>	<p>When entry to the service has been declined, the potential resident and where appropriate their family are informed of the reason for this and of other options or alternative services. The pre-entry form and discussion with the manager records the reason for declining, contact with the family and alternative options are discussed. The manager reports that where a resident has had an appropriate assessment and there is an available bed, no</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>		<p>residents have been declined entry.</p> <p>The sighted admission agreement contains sections on the conditions in which the agreement can be terminated and changes to the level of care. The services will ensure that if they are no longer able to meet the needs of the resident (eg, require hospital level of care) there will be an appropriate reassessment. The service will assist to find an alternative service provider and ensure the transfer occurs in an appropriate and timely manner.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The needs, outcomes, and/or goals of residents are identified through the assessment process and are documented to serve as the basis for care planning and service delivery. The service uses the interRAI electronic assessment process. The residents' files reviewed have assessment tools completed to develop the long term care plan and reassessment occurs at least six monthly, or earlier if there is a change in the residents' needs. The service also utilises other appropriate assessment tools to assess resident's needs. These include wound assessment, pressure risk, and nutrition and falls assessment.</p> <p>All residents' files reviewed contained completed interRAI assessments which included evidence of this tool in the long term care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long term care plan and short term care plans sighted identified the supports and interventions to achieve desired outcomes. The residents' files reviewed identify that care planning is individualised to reflect resident's assessed needs and interventions and support systems are clearly shown. Interventions are detailed, and interviews with the care staff confirm the information ensures continuity of care. Interviews with family and the NP confirm that care is provided by staff who have excellent knowledge and skills.</p> <p>The residents' files reviewed demonstrated service integration. Residents have one main folder that contains their medical information, nursing assessment, care plan, routine observations, activities, therapies, multidisciplinary reviews and correspondence including off site consultations. The current progress notes are in a separate folder, and then placed into the resident's main clinical file. There is integration within the progress notes and files, with input recorded from the care staff, GP, laboratory results, referrals and specialist consultation records. The electronic records (eg, care plan) are printed and a copy is maintained in the resident's folder.</p> <p>All residents' files reviewed contained interRAI assessments and this information was used in the long term care plans.</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>CI</p>	<p>The provision of services and interventions are consistent with, and contribute to, meeting the residents' assessed needs, and desired outcomes. The care plans reviewed confirmed care planning is individualised and personalised to be a true reflection of each resident's assessed needs. When required additional short term care plans or clinical pathways are utilised (eg, falls minimisation and end of life care). As observed at the time of audit the care is resident centred and residents are given choices of times and type of care interventions.</p> <p>Evaluation of a project which demonstrated a reduction in falls and use of medication was reviewed and demonstrates continuous improvement (refer criterion 1.3.6.1).</p> <p>Interviews with the caregivers confirm they use documented interventions to provide appropriate care for each resident. If an intervention is not working well it is reported to the RN or manager who then evaluates the resident's progress and resources current accepted best practice to assist in resolving any issues. The family members confirmed they are highly satisfied with care and interventions provided by the service.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activity coordinator is employed full time and has attended the course on Spark of Life. She is supervised by a diversional therapist from another care facility within the group who is a qualified teacher in the Spark of Life Philosophy. Since the implementation of this programme the number of incidents and accidents has reduced.</p> <p>Evidence is seen of staff education and this includes pet visiting, spontaneity club and the feel good club. Documentation is reviewed every six months and is part of family meetings. Clubs as part of the Spark of life contain assessment tools to ensure which club is suitable for each resident.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Where progress is different from expected, the service responds by initiating changes to the long term care plan or by the use of short term care plans or clinical pathways. Short term care planning was sighted for infections, falls minimisation, acute conditions and wound care as confirmed in the notes of the resident reviewed using tracer methodology. The short term care plans document the interventions are analysed, reviewed, discussed with the family and evaluated for achievement towards clearly set out goals. If the interventions are not working well they are changed and staff are informed. The families interviewed confirmed that were very high satisfaction with the care provided.</p> <p>The care plan evaluations sighted were documented, resident-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>

		Evaluations are documented, consumer-focused, indicated the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Referrals are made to other medical services by the RN or GP as appropriate. Records of referrals are sighted in the residents' files reviewed. Health services accessed include general medicine, surgical services, cardiology, radiology, dietitian, mental health, ophthalmology, immunology and oncology. The NP confirmed that appropriate referrals to other health and disability services are well managed at the service.
<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	Chemical and hazardous substances are securely stored in the laundry. Hazardous substances are correctly labelled, which include precautions for use and safety instructions. Staff have access to safety data sheets for all chemicals and hazardous substances. Staff follow procedures for the safe storage and disposal of waste. There is personal protective equipment (PPE) available to staff. Staff were observed to be using PPE appropriately. Cleaning/laundry staff have ongoing training on waste management, the use of chemicals and infection prevention and control. Staff demonstrated knowledge in the use of PPE and the management of waste.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	FA	<p>There is a current building warrant of fitness.</p> <p>The organisation now owns the building, as this was previously leased. The service have a systematic renovation and maintenance programme. Hot water temperatures and building temperatures are monitored monthly, with the</p>

<p>provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>temperatures in the required ranges.</p> <p>Medical equipment evidences annual calibration. The electrical equipment is test and tagged.</p> <p>The service is a specialist secure dementia unit, which is designed to allow residents with cognitive impairment to wander freely and safely. The secure gardens are accessed by ramps off the lounge and corridors. Residents were observed to wander freely.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are three lots of toilets and showering facilities located throughout the service. These are clearly identified for the residents' use. The surfaces in the amenities are intact for ease of cleaning and infection prevention and control. There are separate toilet facilities for staff and visitors. Families reported satisfaction with the toilets and showers at the service.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate space in each resident's room for the resident and their personal items. Shared rooms are separated by privacy curtains. Staff and families report adequate space in the resident's rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment,</p>	<p>FA</p>	<p>The dining and lounge areas are in separate areas. The activities in each of these spaces do not impact on each other. Families and staff report satisfaction with the lounge, dining and recreational areas.</p>

<p>Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The chemical supplier provides a report on the monthly monitoring of the chemicals and equipment in the laundry and kitchen. The laundry and cleaning equipment storage areas are secure and not accessible by the residents. There is a cleaning schedule that includes daily and weekly programmes. The service conducts regular cleaning and laundry audits, where any shortfall that are identified are actioned. The family satisfaction survey records positive feedback for the cleaning and laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is a fire service approved evacuation scheme. There are six monthly fire evacuation drills, with the last drill conducted in February 2015. There is monthly and annual fire and building warrant of fitness inspections. The firefighting equipment is last checked by the contracted fire protection provider in March 2015.</p> <p>Staff receive appropriate training and education to respond to emergency situations. There are emergency, first aid and outbreak supplies to deal with emergency situations. There is the required amount of food and water supplies in the event of a civil defence emergency. There is an onsite generator for emergency power supply.</p> <p>There is not an inbuilt call bell system in resident's rooms as the residents have cognitive impairment and do not have insight into their use. The service has assessed the cords on call bells as a safety risk for residents with cognitive impairment. Sensor mats are used as required to alert staff when a resident is getting out of bed. Staff have access to an emergency call system to summon other staff for help.</p> <p>The service provides secure dementia services and there are appropriate security arrangements to maintain a safe and secure environment for the residents. There is a night time security checklist. There are security cameras in common and external areas, with the monitoring station in the manager's office.</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>All resident areas and bedrooms are adequately heated and ventilated. There is central heating throughout the service and additional wall mounted electric heaters. All resident areas have at least one external window or glass door for natural light and ventilation. The service has an additional ceiling ventilation system.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The responsibility for infection control is clearly defined with lines of accountability for infection control matters within the organisation leading to the senior management. The infection control coordinator is the RN and they have a job description that has the role, responsibilities and accountability for infection matters defined.</p> <p>The documented infection control programme is reviewed at least annually. The annual review covers quality improvements, policies, procedures, surveillance, staffing, standard precautions and education.</p> <p>Staff and/or residents and visitors suffering from, or exposed to and susceptible to, infectious diseases are prevented from exposing others while infectious. There is a policy for staff not to come to work if they are unwell, there is a notice at the front door advising visitors not to have contact with residents if they are unwell or have been exposed to infections, and at times residents may be isolated where possible and practical.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet</p>	FA	<p>The infection control meeting is incorporated into the staff meeting. The infection control coordinator communicates the monthly infection control report to the staff through monthly email notices. The infection control coordinator has the range of skills, expertise, and resources necessary for the implementation of the infection control programme. The infection control coordinator reports that advice was sought from the GP, DHB and infection control specialist on the management of any outbreak.</p> <p>The infection control team/personnel and/or committee have access to persons with the range of skills, expertise, and resources necessary to achieve the requirements of this Standard.</p>

the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The service utilises updates from an aged care consultant to review their organisational policies. The staff observed at the time of audit demonstrated good infection prevention and control techniques. The staff demonstrate good knowledge of policies and procedures for infection prevention and control.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice. The infection control coordinator and specialist infection control resources are utilised for the staff in-service education. The infection control coordinator attends ongoing education on infection control and demonstrated knowledge of current best practice for infection prevention and control.</p> <p>Resident education occurs in a manner that recognises and meets the communication method, style, and preference of the resident. The infection control coordinator has conducted informal education with residents, such as education on the recent scabies management. The staff interviewed report they receive adequate education on infection prevention and control.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for</p>	CI	<p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. The monthly surveillance data is collated and analysed by the infection control coordinator. The</p>

<p>infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>surveillance data and analysis of infections recorded that upper respiratory tract infections are the most common infection over the year, which shows that these are indicative of resident mobility and seasonal infections. The service sought infection control and outbreak advice from the DHB and GP in the treatment and management of an outbreak. The action plan for the outbreak management includes contributing factors to the event, treatment, review of systems and the environment.</p> <p>A continuous improvement is attained for a project which analysed infection numbers and implemented initiatives to reduce the number of infections (refer criterion 3.5.7).</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has no restraint use and one resident who uses an enabler. The organisational policy clearly identifies enablers as voluntary and the least restrictive option to maintain safety, comfort and dignity. The enabler that is in use is an all-in-one stay dry device that restricts the residents hand access to their continence product. This is used with the consent of the resident and their EPOA/family. The care plan and consent forms record that the device is voluntary and the best option for the resident to maintain their night time dignity and reduce anxiety. Staff attend ongoing education on restraint minimisation and demonstrate knowledge on enabler use and restraint minimisation. The unit provides a secure environment for residents with cognitive impairment to wander freely.</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.

No data to display

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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	CI	<p>The service has conducted a six month quality improvement project into accidents and injuries. The project included implementing the Spark of Life approach on how to reduce falls. The service has undertaken analyses and trending of the falls data and the information on the accident/incident forms. The incident/incident form was amended to include more detailed information that included greater analysis of the time and location of any incidents. Through increasing activities throughout the day and implementing activities at the higher risk ‘sun downing’ time in the afternoon, the service has been able to significantly reduce the amount of falls. Through the analysis and evaluation of the incidents and accidents the service has been able to increase resident safety by reducing falls and injuries.</p>	<p>The achievement of the quality improvement project into reduction of incidents and accidents is rated beyond the expected full attainment. The service has conducted the project over six months and this included a documented review process with analysis and reporting of findings to staff and management. There is evidence of action taken based on findings and improvement to service provision. Resident safety has been measured by evidencing reduction in falls and injuries. Family satisfaction is measured through surveys and feedback, with all reporting positively of the actions taken to manage their relatives effectively and minimise falls and injuries to their relatives.</p>

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>CI</p>	<p>The service has conducted a quality improvement project related to their education programme. The project includes the analysis of the external Aged Care Education (ACE) and internal education programme and the Spark of Life Practitioner's training for the activities coordinator. The project included a review of what the opportunity for improvement was, the review process and how this was measured, the actions implemented and what benefits and desired outcomes were achieved. With the quality improvement project into the education programme, the organisation measured that there was an increase in staff obtaining their national qualifications. The analysis records that an increase in staff knowledge about specialised dementia has led to overall improvements in the quality of care. There has been a reduction in medication use, less wandering and challenging behaviours, less falls and staff morale has increased. Families report high satisfaction with the quality of care and management of their relatives challenging behaviours.</p> <p>With this project, and the training of the activities coordinator to become a registered Spark of Life Practitioner and increased education with families on dementia care, the service's philosophy is having a positive impact on the quality of care and service delivery. The Spark of Life Practitioner provides weekly training and education for staff on the Spark of Life, the resident centred approach to care and service delivery. Family satisfaction survey's record positive feedback on the activities, environment and overall improvement in care and service delivery. With increased staff satisfaction, as recorded in satisfaction surveys and staff meetings, there has been less staff turnover. This in turn, is recorded as staff becoming more familiar with the residents' individual needs and idiosyncrasies and rapport with families. With the increased family education on dementia and the Spark of Life approach, the families have reported that they are now more confident in the management of their family members and has resulted in them wanting to visit more frequently to enjoy the time they spend with their relatives.</p>	<p>The achievement of the quality improvement projects in ongoing education and the Spark of Life are rated beyond the expected full attainment. With these projects there has been a documented review process which includes the analysis and reporting of findings. The projects include documenting actions to make improvements in the education programme, increase staff knowledge and skill in care of the resident's living with dementia. Positive outcomes have been measured in staff, resident and relative satisfaction.</p>
<p>Criterion 1.3.6.1</p> <p>The provision of</p>	<p>CI</p>	<p>A quality project was undertaken to assess any changes in residents that could result in the reduction of falls, wandering and use of medication for</p>	<p>The achievement of the quality project into service delivery and interventions is rated</p>

<p>services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>agitation and restlessness. Strategies implemented included updating education with all staff regarding the management of challenging behaviour, completion of modules with 'ACE' education towards a certificate of care of the elderly, attendance at Age Concern workshops, reviews with the nurse practitioner and the GP reviewing medications of all residents and particularly antipsychotic medications.</p> <p>The project was evaluated and falls were reduced, medications reduced and as part of the Spark of Life programme, an increase of hours of the activity coordinator during evening meal times.</p>	<p>beyond the expected full attainment. The project included a documented review process with analysis and reporting of findings to staff and management. There is evidence the service has been able to reduce falls, reduce the use of antipsychotic medications and improve the management of challenging behaviours. Family satisfaction is measured through surveys and feedback and analysis of medications, with all reporting positively of the actions taken.</p>
<p>Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>CI</p>	<p>A project was undertaken to review the infection results of the past four years and to implement some changes to reduce the numbers of infections. Some of the initiatives introduced were the employment of a RN, who with the assistance of the NP, has reviewed policies and procedures with staff education, increased hours of the activities coordinator ensured residents were happy and motivated which resulted in less infections, staff morale improved and they felt valued and sick days decreased and education regarding infection prevention became part of the daily schedule.</p> <p>Infections reduced from a total of 86 in 2012 to 57 in 2014.</p>	<p>The achievement of the quality project into infection prevention and control is rated beyond the expected full attainment. The project included a documented review process with analysis and reporting of findings to staff and management. There is evidence the service has been able to reduce the number of infections, which has also had the effect of reducing the number of challenging behaviours. The impact on resident safety has been measured by evidencing the reduction in number of infections. Family satisfaction is measured through surveys and feedback, with all reporting positively of the actions taken.</p>

End of the report.