

Heritage Healthcare Limited - Karetu House

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 Health Audit (NZ) 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: Heritage Healthcare Limited

Premises audited: Karetu House

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 14 July 2016 End date: 15 July 2016

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: 40

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
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

Keratu House is an aged care service owned by the Heritage Healthcare Limited and is a family owned and operated company. Rest home level of care is provided for up to 43 residents, with 40 residents at the service at the time of audit. One of the areas of expertise of the service is providing support to residents who require input from the community mental health services. The strength of the service includes encouraging independence though enhancing connections within the local community. All the residents and family/whanau report satisfaction with the care and services provided.

This certification audit was conducted against the relevant Health and Disability Services Standards and the service's contract with the district health board. The audit process included the review of documentation, observations and interviews. The onsite documentation review of residents' files. Interviews were conducted with the management team, clinical and non-clinical staff, residents, family/whanau, a gerontologist, a community mental health nurse practitioner and a general practitioner to verify the documented evidence.

The service has gained one rating of excellence (continuous improvement) for the activities related to residents being supported to maintain links with the community.

There are four areas that need improving related to the clinical/care documentation. These include ensuring contractual time frames are met, ensuring the care plans reflect the assessed needs, ensuring evaluations are documented and ensuring there is sufficient detail on the medication system.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrate knowledge, understanding and how to implement the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights) into service delivery. Residents and their family/whānau are informed of their rights at admission and throughout their stay. There are copies of the Code of Rights posters, brochures and information relating to the Nationwide Health and Disability Advocacy Service available in the residents packs and displayed throughout the service.

Residents and family/whānau receive services that respect their dignity, privacy and independence. The residents' ethnic, cultural, spiritual and gender identity values are respected. Residents who identify as Maori have their individual cultural values and beliefs integrated into service delivery.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. The service has links with community mental health supports to meet the needs of the resident population. Residents have access to visitors of their choice and are supported to access community services, this is a strength of the service.

Evidence was seen of informed consent and open disclosure in residents' files reviewed. Interpreting services are contacted when required.

The service has an easy to use complaints management system. There is a complaints register that contains any complaint received and actions taken to address any shortfalls.

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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Heritage Healthcare's owner/general manager ensures that business and strategic planning is in place to cover all aspects of service delivery at Karetu House. This is reviewed and updated annually with input from Karetu House's facility manager. The annual business plan which is personalised to the services offered and strategic goals reflect organisational planning outcomes. The facility manager is responsible for the overall management of the service. The facility manager is supported by general manager and registered nursing staff for clinical responsibilities. The facility manager is suitably experienced to run the service.

Policies are reviewed by the Heritage Healthcare on a two yearly cycle, or sooner if there are changes in legislation or best practice. The quality and risk performance is reported through meetings and quarterly analysis at the facility. Quality and risk management activities and results are shared among management, staff, residents and family/whānau, as appropriate. The quality and risk systems are also monitored by the wider Heritage Healthcare group of facilities formally two monthly and more frequently informally (at least weekly). Review of service delivery includes incidents/accidents, infections, complaints and reports from the internal audit programme.

The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established. There are adequate staff numbers each shift to meet the resident's needs. There is an education programme for all staff is available and planned for the year. The education, training and orientation processes for staff have are linked to improved outcomes for residents.

At organisational level there is a clinical governance group to oversee any issues that occur and to provide oversight of all major clinical projects. At facility level the quality and risk system and processes support effective, timely service delivery. Corrective action planning is implemented to manage any areas of concern or deficits. The quality management systems include an internal

audit process, complaints management, incident/accident reporting, annual resident surveys, restraint and infection control data collection.

Record management meets the requirements of the standards. There is no resident information that is accessible to public.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The entry requirements for rest home level of care are clearly documented. Residents and family/whanau receive accurate information on admission to the service. If a potential resident is not able to be admitted a record is maintained and the potential resident and/or their family/whānau are informed.

The processes for assessment, planning, provision, evaluation, review, and exit are provided within time frames that safely meet the needs of the resident and contractual requirements. The service has implemented the required electronic assessment tool (interRAI) and an electronic format for the care planning. The care plans described the required support and/or intervention to achieve the desired outcomes. The evaluation record showed the progress the resident is making towards meeting their goals. Where progress is different from expected, the service responds by initiating changes to the care plan or with the use of short term care plans. The service is coordinated in a manner that promotes continuity in service delivery and a team approach to care delivery.

Referral to other health or disability service providers is appropriately facilitated by the general practitioner or registered nurse. There is an appropriate process and risk assessments to facilitate any discharge or transfers to other providers.

The service provides a planned activities programme to develop and maintain skills and interests that are meaningful to the residents. There have been a number of quality projects implemented in relation to the programme.

There are processes in place for safe medicine administration. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

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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There are processes in place to protect residents, visitors, and staff from exposure to waste and infectious or hazardous substances, and to provide safe and hygienic cleaning and laundry services.

All building and plant complies with legislation with a current building warrant of fitness displayed. Ongoing maintenance ensures the building is maintained to meet the needs of the residents. There are planned renovations for the kitchen and continuing with the replacement of the carpeting. Fixtures, fittings, floor and wall surfaces are made of acceptable materials for the rest home environment.

All rooms have access to hand basins. One wing has full ensuite facilities in each room with other communal showering and toilet facilities located in each of the wings. There are adequate numbers of toilets and showers.

There is a mix of single and shared rooms, with each room having adequate space and amenities to facilitate independence.

The facility has an appropriate call system installed. There is easy access to external gardens, grounds and court yards for residents and their visitors. The physical environment minimises the risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents.

Routine safety checks and internal audits are performed by maintenance personal and management. Emergency preparedness was evident with adequate resources being available in the event of an emergency. Staff are trained appropriately in all aspects of health and safety in the work place.

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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Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. At the time of audit there is no restraint or enablers in use. Restraint approval and assessment processes are known to staff.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed quarterly and annually.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and are readily available for staff.

Infection control education is provided as part of the in-service education by external providers. The education is relevant to the rest home setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to staff. The GP, or other specialised input, is sought as required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	41	0	0	4	0	0
Criteria	1	88	0	0	4	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>Staff demonstrated knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the Code is included in staff orientation and in the annual in-service education programme. Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents reported that they are treated with respect and understand their rights. The family/whānau and visiting specialist reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The residents' files had general consent to care forms signed by the resident or their next of kin/enduring power of attorney (EPOA). It is recorded in the resident's file and on a register if the EPOA has been activated. There are specific consent forms for other medical procedures such as vaccinations.</p> <p>Staff acknowledged the resident's right to make informed choices and respecting any end of life wishes (including knowledge of culturally appropriate end of life care). There is information on display if the residents wish to access support to develop an advance care plan. Residents and family/whānau expressed no concerns related to informed consent.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>The residents and family/whanau reported that they were provided with information regarding access to advocacy services as part of the pre-admission and admission processes. There is a list of independent advocates displayed on the resident's noticeboard. Education on advocacy and support is conducted as part of the ongoing education programme. The residents and family/whanau did not express any concerns regarding access to advocacy and support</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and visitors are encouraged to visit. Residents were observed to be accessing the local community resources independently. The service has links with local schools, religious, marae and community activity services.</p> <p>Residents are supported and encouraged to access community services with visitors, with a project being conducted on residents being able to access public transport.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The sighted complaints policy and process complies with Right 10 of the Code. The complaints register identified complaints have been managed within policy time frames. The complaints register records all complaints, dates and actions taken. The complaint register also recorded what Right the complaint relates to. There are no complaints recorded to date in 2016. A complaint from 2015 was sampled. There were no open complaints at the time of audit. Residents and family/whānau confirmed that the management's open door policy makes it easy to discuss concerns at any time.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code is explained to residents as part of the admission process and reinforced at resident meetings or individually with residents as required. The resident satisfaction survey includes the residents understanding of the Code, and if the resident requires any further clarification on the Code this is actioned. Information on the Code and advocacy services is displayed throughout the facility and is available in poster and brochure formats in a variety of languages. A list of advocates and their contact numbers are displayed. The residents did not express any concerns regarding their rights not being respected.</p>
<p>Standard 1.1.3: Independence, Personal</p>	FA	<p>In shared rooms there are dividing curtains for visual privacy. The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the</p>

<p>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>protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed. Staff report knowledge of residents' rights and understand dignity and respect.</p> <p>Residents individual beliefs are captured in care planning and service delivery. The resident and family/whanau reported that encouraging independence and respecting their individuality is a 'real strength' of the service.</p> <p>The residents and family/whanau did not express any concerns regarding abuse, neglect, discrimination or their privacy being breached, all resident spoke highly of the manner in which the staff interact with them.</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>The service has a number of residents who identify as Maori. Interviews with residents report that their cultural and family/whanau values are respected. One resident reports that they specifically chose this rest home due to the number of Maori residents at the service. The individual cultural values and beliefs are identified in the care plan and staff demonstrated knowledge of individual resident and whanau values and beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The resident's individual values and beliefs were recorded in the care plans, including culture and sexual/gender identity. The plans also identify the variety of beliefs that person may express during psychosis events and how to manage these. All files evidenced the care was developed in consultation with the resident, and where relevant, the family. The family/whanau reported that the service meets the individual needs of their relatives. Staff demonstrated knowledge in respecting and meeting the individual cultural needs, values and beliefs of each of the residents. There are residents and staff of varying cultural backgrounds at the service.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Individual employment contracts, house rules and policies have information on professional boundaries. The orientation and induction programme includes staff education on maintaining professional boundaries. The residents and family/whanau reported they have no concerns about discrimination.</p>
<p>Standard 1.1.8: Good Practice</p>	FA	<p>Evidence-based practice was observed, promoting and encouraging good practice, especially in</p>

<p>Consumers receive services of an appropriate standard.</p>		<p>relation to the management of challenging behaviours and mental health issues. The service has been a pilot site for working with the mental health services in managing specialist medications in the community setting. There are weekly visits by mental health practitioners.</p> <p>Policies and procedures are linked to evidence-based practice and there are a number of resources available from specialists, such as wound management, pressure injury minimisation and challenging behaviours. There are regular visits by the GP and links with other health providers such as, Maori Health providers and palliative care services.</p> <p>There is access to external education that is focused on aged care and best practice. The in-service and external education provided covers the contractual requirements and specific needs of the resident group. When staff attend external education sessions, they disseminate this information to other staff and health professionals. Staff reported that they were satisfied with the relevance of the education provided.</p> <p>The residents and family/whanau expressed high satisfaction with the supports and services proved at Karetu House.</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>The service promotes an environment that optimises communication through the use of interpreter services as required. Interpreting services have been accessed for a resident who has English as their second language as part of their initial assessment on entry to the service. The staff report they are able to communicate effectively with residents who do not have English as their first language.</p> <p>Documentation of open disclosure following incidents/accidents is evident. The monthly residents meeting provides an opportunity for bringing up any issues.</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>The service has a maximum capacity of 43 residents. On the day of audit 40 beds were occupied, all are rest home level of care and include three younger people under the age of 65 (with the youngest aged 35). The service has a number of residents at rest home level of care who also have identified mental health issues. The services are managed to recognise and meet the needs of a range of ages, gender mix and cognitive needs of the residents.</p> <p>The organisation has a business plan which identifies the organisation's mission statement, vision and philosophy and shows the organisation's planning process to meet residents' needs. Strategic planning is undertaken yearly to ensure the services offered meet residents' needs. This is reflected in the business plan goals and objectives sighted which covers all aspects of service delivery. The business planning includes an assessment of the strengths and weakness</p>

		<p>of the service. There are formal management meetings two monthly to review progress with the set goals, with more informal verbal and email communications with the owner/general manager.</p> <p>The service is managed by an experienced manager with over 10 years managing the service. The facility manager has a health and mental health services background. The facility manager is supported by the general manager (who is a registered nurse) and onsite registered nurses. The facility manager has attended over eight hours' education in the past 12 months related to the management of aged care services and clinical management of residents. The facility manager gains regular updates from an aged care association on current issues and direction in aged care.</p> <p>The staff and residents report the facility manager is approachable and addresses any concerns they may have.</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>	<p>FA</p>	<p>During a temporary absence of the facility manager the general manager (RN) takes on the facility manager's roles. The facility manager reports confidence in the general manager and staff's ability to take on the management role during temporary absences to provide continuity of care.</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>	<p>FA</p>	<p>The quality improvement plan describes objectives, goals and actions taken. The quality and risk management system is understood and implemented by the staff. This includes the development and updating of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. All corrective actions are reviewed and evaluated. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Information collected informs ongoing planning processes to ensure residents' needs are met.</p> <p>The policies and procedures are reviewed at least two yearly or sooner if there are changes to best practice or legislation. The policies reflect best practice and link the specialist resources and information, such as current pressure injury prevention and management. Staff only have access to the current policies, with staff updated on any changes in policy through staff meetings and the staff notice board. There is an archive system in place for obsolete</p>

		<p>documents.</p> <p>The key components of service delivery are standing agenda items for management and staff meetings. All data is collected monthly, collated, trended, reviewed by management and corrective actions put in place if any deficits are noted. There is an Additional quarterly review of the data, with this also presented at the staff meeting and provided to the general manager. Each key component has a set quality goal which is regularly reviewed and evaluation is documented to indicate how improvements have impacted on resident satisfaction and/or safety. Information is used to inform business and strategic planning processes. Staff, resident and family/whānau interviews confirmed any concerns raised have been addressed by management and verbal examples of quality improvements were given.</p> <p>There is monthly and annual collation, analysis and evaluation of the quality data. The information is shared with staff, residents and family/whānau as appropriate. This includes information being published in the newsletter. The service has also contributed to external quality data on falls and pressure injury reduction through the DHB.</p> <p>Clearly documented information is available to all staff and the continued improvement process is overseen by management. Staff, residents and family/whānau interviewed confirmed they feel included and well informed about any new processes put in place. Some recent quality initiatives include the review of the medication charting system, focus on skin care and recording of the application of topical treatments, advance care planning and the use of the Glasgow Coma Scale after a resident has had a fall.</p> <p>Corrective action processes inform the quality goals to ensure residents' needs are being met. Corrective action plans have been developed from all quality processes where a deficit has been identified and/or to related to ensuring best practice standards are maintained following staff education or to meet legislative requirement changes. The corrective actions are decided by the management team and shared with staff at handover and at staff meetings. As staff implement the actions, their input into the evaluation of corrective measures taken is documented and discussed. If a corrective action appears not to be working, then actions are changed so the service can reach their required quality goals. This process is clearly documented on the corrective action form, staff meetings and quarterly reports/analysis.</p> <p>Actual and potential risks are identified and documented in the hazard register. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes</p>
Standard 1.2.4: Adverse Event Reporting	FA	The facility manager understands their obligations for reporting serious harm and essential

<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>notifications, including their responsibility to report stage 3 and above pressure injuries.</p> <p>Staff demonstrated knowledge of when they are required to complete an incident/accident form. There is a monthly and quarterly analysis of the incident/accident/adverse events. The analysis of the adverse events is used to implement improvements. The ongoing strategies are discussed at staff meetings. The analysis includes the numbers of falls and the times that falls are occurring for residents who have had increased falls and incidents of challenging behaviours, with strategies implemented to reduce the number of falls or better support the residents to reduce challenging behaviours.</p> <p>As part of the pre-audit, feedback was sought from the DHB and no issues were raised.</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>Professional qualifications and annual practising certificates (APCs) are validated on employment and annually. The service maintains a folder of current APCs, sighted for all staff and contractors who require them.</p> <p>The staff files evidenced that good employment processes are implemented, such as recruitment, interview, reference checking and police vetting. After the orientation period there is then a performance review annually. Orientation includes the essential and emergency systems, handling concerns and complaints, cultural best practice, infection control, incident/accident reporting, managing challenging behaviours and restraint minimisation. Staff reported that the orientation and induction gave them a good understanding of their role and responsibilities.</p> <p>The staff have access to in-service and external education. The education programme covers the essential components of service delivery for rest home level of care and the services focus on management of residents with mental health issues. The service also accesses ongoing education support from the DHB aged residential care programme, gerontology nurse specialists, other local aged care facility and palliative care services. The education includes pressure injury minimisation and management. Attendance records are kept for the education that staff have attended, as sighted in each of the staff member's personnel files and attendance sheets. An RN who is part of the Heritage Healthcare services does the interRAI assessments has completed their interRAI competency training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate,</p>	<p>FA</p>	<p>There is clearly documented policy on staffing levels and skill mix to meet the needs of residents requiring rest home level of care. There is at least two care staff on duty at all times, with four caregivers on a morning shift. There is at least one RN on duty Monday to Friday and</p>

<p>and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>on call after hours. In addition to the direct care staff, there is a facility manager on duty Monday to Friday. The RNs share afterhours on call and the GP practice is available after hours. There is at least one staff member on duty each shift who has current first aid qualifications. There is appropriate staffing level for activities, cooking and cleaning. The caregivers assist with the laundry duties. Staff reported they have sufficient time to complete the duties they are required to do each shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Administrator information is entered into the residents file on admission. A register is kept of current and past records. The records of past residents are securely destroyed within time frames that comply with legislation. Archived records are stored securely on site; these are retrievable as required. The electronic records are password protected and secure log in is required to access resident information. All records pertaining to individual residents are integrated. The progress notes record the staff members name and designation.</p> <p>Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable. The residents' files are securely stored in a locked cabinet in the office.</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>	<p>FA</p>	<p>Entry to service is overseen by the facility manager. When an enquiry is made for rest home level care the service ensures that all residents have a needs assessment completed by the required referring agency. This is confirmed in the resident file reviews undertaken. Bed availability information is updated on Eldernet Monday to Friday. Information contained in the resident information booklet describes the service available. Discussions with the resident and family/whanau as appropriate prior to entry ensures all aspects of the service are discussed and understood.</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>	<p>FA</p>	<p>The service implements policy related to transition, exit, discharge and/or transfer to ensure all documentation is provided to allow a safe transition. When a resident is transferring to the general hospital the DHB transfer form is used to ensure all data required is captured. A copy of the resident's medication chart, known risks such as high falls risk and advanced directives are included in the relevant documentation sent using the 'yellow envelope' system. Any concerns the family/whanau or the resident may have, are also documented.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The service has a prepacked medication delivery system in place. The storage, review, administration and disposal of medication complies with required guidelines. The GP conducts medicine reconciliation when residents are admitted to the service. Timeframes are not met related to the three monthly ongoing checks as shown in criterion 1.3.3.3. Medicine file reviews showed that each medication was individually signed. It was noted that some medication being given long term is charted under short term medication on the medication chart. The controlled drug storage, register and administration met requirements.</p> <p>There were no residents self-administering their medications at the time of the audit. There are policies and procedures if a resident is assessed a competent to self-administer their own medications. The standing orders used at the facility meet requirements and cannot be given without the consent of a RN.</p> <p>The staff responsible for medication management have all completed medication competency validation and on-going education relating to medication management. The service implements reconciliation processes which include six monthly checks by the pharmacist and the checking of all pre packed medications for accuracy by the RN when delivered to 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>The service has a four-week cycle/rotational menu with seasonal variations. The menu was last reviewed by a dietitian in September 2015. The menu audit is based on Dietitian's New Zealand menu audit tool. The menu review records that overall the menu is 'very good' with variety and is appropriate to the resident population.</p> <p>Residents are routinely weighed on a monthly basis, with anyone with a clinical need weighed more frequently. The staff report that they do not have current concerns with unexplained weight loss. A copy of each resident's nutritional assessment is provided to the kitchen staff, with a list maintained of any specific diets, texture modification or additional nutritional supplements.</p> <p>The kitchen cupboards in one section of the kitchen have chipped surfaces, one section of the kitchen has already been replaced. The replacement of the remaining surfaces is part of the maintenance plan, (as sighted in email communication with the supplier and interview with the general manager). The food temperature is monitored and recorded at each meal, these sighted temperatures are within food safe guidelines. The foods in the fridge, freezer and pantry are in their original packages, or covered and labelled if they have been decanted. The kitchen processes include stock rotation, monitoring of expiry dates, cleaning schedules and pest</p>

		control. The kitchen staff have food safety qualifications.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The facility manager confirmed that they only decline requests where services offered do not meet resident requests or if the bed status is full. If a referral is not accepted the resident, the referrer, prospective resident and family/whanau are informed of the reason why, with this recorded on the enquiry form.</p> <p>The admission agreement is developed through an aged care association that is then personalised to the service. The agreement has clauses on the change in level of care process when the service can no longer meet the needs of the resident.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All assessments and re-assessments are conducted using the electronic interRAI process. One interRAI assessment has not been undertaken since January 2015. The service uses additional paper assessment tools as required such as behavioural and pain assessments. The information gathered during assessment serve as the basis for service delivery planning. This is confirmed in the resident files reviewed where assessment information is shown on either the long or short term care plans. Refer to comments in criterion 1.3.5.2.</p> <p>One assessment was overdue; this is not a systemic issue. Refer comments in 1.3.3.3.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>The residents' files reviewed identify that care plans are resident focused, they cover all aspects of care including requests from other health care providers that indicate the continuity of service delivery. This is confirmed by interviews conducted with the visiting community mental health nurse and the GP. However not all the information captured during ongoing interRAI assessments are evident on the resident care plan.</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>	FA	<p>The services and interventions are consistent with meeting the needs and wants of the residents. This is confirmed during resident and family/whanau interviews. Resident records are personalised with individualised interventions documented on both long and short term care plans sighted.</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 planned activities for residents are individualised and are meaningful to reflect each residents' likes, abilities and needs. The activities are planned and overseen by the diversional therapist. All staff and trained volunteers are actively involved in ensuring resident's activities needs are met. Each resident has input into the planning of the activities they wish to pursue. One example identifies that a resident goes to an off-site gymnasium and swimming pool as part of their usual planned activities. This is linked to a weight loss programme which is overseen by a dietitian.</p> <p>The activities programme covers physical, social, recreational and emotional needs of the residents. The residents talked about the activities they attend and stated they really enjoy what is offered. Residents were observed to be going offsite with family/friends and to planned activities. Also refer to comments in criterion 1.1.12.2.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>The organisational policy records that evaluations will be conducted at least six monthly. Whilst assessments are generally undertaken six monthly no evaluation data is documented to indicate the degree of achievement or response to the support and/or interventions put in place or the progress made toward the resident meeting their desired goals could be found. (One documented evaluation sighted was dated 2014). The manager thinks that the RNs consider the interRAI assessment updates to be evaluations. This was discussed on the day of audit and she will remind staff to use the evaluation sheets as shown in policy.</p> <p>When there are changes in the resident's needs, the service uses a short term care plans to capture these changes. Refer comments in criterion 1.3.5.2. The short term care plans identify the needs, interventions and evaluation of the interventions.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are given the choice of keeping their current GP or using the GP associated with the facility. Referrals to other health care services is made by the RN or the GP as appropriate. This is documented in the resident files reviewed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	<p>FA</p>	<p>The laundry and chemical storage area are secure and provide appropriate storage of waste, infections or other hazards materials. The general waste disposal and recycling is conducted by</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>		<p>the local council. Any clinical waste and sharps is conducted by contracted service providers. Personal protective equipment (PPE), such as disposable gowns, gloves and eye protection is available. The staff were observed to be using the appropriate PPE and demonstrated knowledge of when to use the PPE. The staff receive annual training on the management of waste and use of PPE.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed. A monthly safety inspection is recorded, this records environmental inspections, inspection of the furnishings and equipment and review of the civil defence supplies. The electrical equipment evidenced current test and tag inspection labels, appropriate to the type of equipment and environment. Annual calibration of the medical equipment was last conducted in February 2016. There is a monthly recording of the hot water temperatures, the readings were within the required range.</p> <p>The physical environment minimises risk of harm with an uncluttered corridor with secured hand rails. The floor surfaces are intact, some carpeting is showing signs of generalised wear and tear, with the service in the process of replacing the carpet. There is ramp and stair access to external areas. There are courtyard and deck areas for the residents, which provided covered seating.</p> <p>The residents and family/whanau reported satisfaction with the environment at Keratu House.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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 is a mix of ensuite and communal shower and toileting facilities. The facilities are located in each of the wings that provide adequate numbers for convenience of access to the residents. There are designated staff and visitor facilities. The surfaces are intact in the toilet/shower facilities. The residents report satisfaction with the toilet and showering facilities.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is a mix of shared and single rooms. In shared rooms there are privacy curtains and each resident has space for their own personal belongings. There is enough space in the rooms to accommodate the resident and any mobility equipment they have. The residents and staff report adequate space in each of the rooms.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has one main lounge and dining area. One of the wings has a smaller lounge and dining area and the other wing has a smaller lounge area. There is adequate space so lounge, dining and activities do not impact on each other.</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 environmental audit and laundry services audits record the effectiveness of the laundry and cleaning processes, including waste management procedures. Both these internal audits were last conducted in February 2016 and record full compliance.</p> <p>The chemicals are securely stored in a locked cupboard and the laundry. The staff demonstrated knowledge of the cleaning and laundry process, which reflects current infection control procedures. The residents and family/whanau report satisfaction with 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>The service has civil defence supplies for emergency use, this includes storage of drinking water and food. There is emergency lighting and back up gas supply for cooking and heating of water. The emergency equipment is inspected monthly by both internal auditing and by the contracted fire/emergency inspection company's independent qualified person. The six monthly evacuation drill was last conducted in May 2016. There is an approved evacuation scheme with a compliance schedule first issued in 1993 and amended in 2006. There is signed approval of the amendments. The staff records identify emergency training and the staff demonstrated knowledge of the actions to take in an emergency situation.</p> <p>Each room, bed space and toilet/shower facilities have access to a call bell. When activated there is an audible alert and a light on a control panel to identify which room has activated the call bell. Rooms in one of the wings also have a light above the door to identify the room that the call bell was activated in.</p> <p>Night time security processes are conducted by the staff, which includes the locking of external doors and windows. The evening staff do rounds to ensure the doors and windows are locked. If staff, residents or visitors require access in the evening, there is a door bell.</p>
<p>Standard 1.4.8: Natural Light, Ventilation,</p>	FA	<p>All areas used by the residents have adequate natural light, heating and ventilation. Each resident room has at least one external opening window. There is central heating throughout the</p>

<p>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>		<p>building. The residents and family/whanau report satisfaction with the lighting, heating and ventilation of the building. All residents report the building is comfortable throughout the year and changing seasons.</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>	<p>FA</p>	<p>The service has a documented infection control programme which is reviewed as part of the annual quality review programme. This was last conducted in January 2016. There is also a quarterly review and analysis of the infections. The infection control programme minimises the risk of infections to residents, staff and anyone else visiting the service.</p> <p>The infection control coordinator is the facility manager in conjunction with the RNs. The infection control coordinator monitors for infections, uses standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is a standing agenda item in the staff meetings. If there is an infectious outbreak this is reported immediately to staff, organisational management, and where required, to the DHB and public health department.</p> <p>The infection control coordinator reported that the staff have good assessment skills in the early identification of suspected infections. Residents with infections are reported to staff at handover.</p> <p>Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at entrances. When outbreaks are identified in the community, notices are placed at the entrance not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are encouraged to stay in their rooms if required, although the infection control coordinator reports that this can be difficult at times with the current resident population.</p> <p>The staff demonstrated good infection prevention and control techniques and awareness of standard precautions, such as hand washing.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the</p>	<p>FA</p>	<p>The facility manager confirmed being responsible for facilitating infection prevention and control activities. They are supported by the RNs for any additional clinical advice. The facility manager has attended relevant education on infection prevention and control and advises they liaise with the GP if there are any concerns about a resident with a known or suspected infection. Additional advice and support on infection control matters can be sought from the microbiologist at the DHB or a private infection control nurse consultant.</p>

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	A copy of the infection prevention and control policies is available for staff to refer to as and when required and this was sighted. Staff confirmed access to policies on infection prevention and control. Staff reported if they had any concerns they would contact the facility manager or RN who is on call when not on site.
<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	Education is provided for staff on infection prevention and control as a component of the orientation and ongoing education programme. Education is provided by an external infection control consultant as part of the annual education programme. Residents and family are provided with advice on infection prevention and control activities through residents' meetings or on a one to one basis. Staff reported they regularly receive education. Vaccinations are encouraged for staff and residents.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance for infections is carried out in accordance with agreed objectives, priorities, and the methodology that is specified in the infection control programme. The surveillance programme reviewed is appropriate for the rest home. Surveillance forms have been developed and implemented for the reporting of infections. Information gained is reported as part of the quality management system requirements and quality improvement objectives on a monthly basis and quarterly overview/analysis. Any immediate trends are reported to staff to implement actions. The infection data for 2015 and 2016 records limited numbers of infections, where there have been any increases, such as increase in urinary tract infections (and associated changes in behaviours) actions are implemented to reduce the reoccurrence.</p> <p>Staff report that they are kept well informed and understood their responsibilities for reporting any signs and symptoms of a resident having an infection.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of</p>	FA	The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. The use of enablers is voluntary and the least restrictive option to meet the

<p>restraint is actively minimised.</p>		<p>needs of the resident. Policy contains all necessary documentation related to the use of restraint. Restraint would only be used if a resident posed a risk to themselves or others.</p> <p>The service is restraint and enabler free at the time of audit. The annual restrain review was undertaken in July 2016 including policy and procedure reviews.</p> <p>Staff verbalised their understanding and knowledge related to restraint and enabler use.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>All medications given are documented on appropriate medication forms. There are up to date photographs of each resident for ease of identification and each medication instruction is signed for by the GP. Not all good practice medication requirements are met. Staff observed administering medications were able to answer questions related to when it may be necessary to withhold the medication such as insulin.</p>	<p>One medication file reviewed had a medicine being given for over one year on a regular basis still charted as a short term medication.</p> <p>One chart also identified a resident who has regular analgesia (three times a day) does not have this in their prepacked medication but it is given on an as required basis (PRN). This has occurred for over three months.</p> <p>There is no documented guidance for residents who have insulin related to when to withhold insulin related to high or low ranges of blood sugar</p>	<p>Ensure that all medicine management information is recorded to a level of detail that complies with legislation and good practice guidelines.</p> <p>90 days</p>

			level recordings.	
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>In six of the seven resident files reviewed assessment, planning and reviews are up to date. One resident file did not contain a recent interRAI assessment and no evaluations could be located.</p> <p>The GP verified verbally that he always undertakes medicine management reviews when he does the three monthly medical reviews. However, the time frames documented on the medication charts did not reflect this.</p>	<p>The timeframes indicated on the resident medication charts reviewed (14) ranged from three to six months. Evaluations are not conducted six monthly and one interRAI assessment is overdue. One assessment was last documented in January 2015.</p>	<p>Provide evidence that each stage of service provision is provided within time frames that safely meet the needs of residents and that they meet contractual and legislative requirements.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Initial service delivery plans describe the required support and interventions to achieve the desired outcomes identified during the assessment process. Not all information captured in the ongoing interRAI assessment process is identified on the residents' care plan. This was evidenced in five of the seven files reviewed. Some information is captured on short term care plans which should be shown on the long term care plan as it is related to deteriorating medical issues.</p>	<p>The ongoing interRAI assessment findings are not consistently being used to inform and update the long term care plans. This was evidenced in five of the seven resident files reviewed. Some long term medical changes are being documented on short term care plans.</p>	<p>Provide evidence that all the information captured on the ongoing interRAI assessments are shown on the appropriate long term care plan.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or</p>	<p>PA Moderate</p>	<p>Regular assessments are undertaken and changes are made to meet resident's needs. However, no current documented evaluations could be located.</p>	<p>In the seven files reviewed, no evaluations to indicate the resident's achievement or response to interventions and progress towards meeting stated goal were sighted.</p>	<p>Provide evidence that evaluations are documented to indicate each resident's degree of achievement or response to</p>

response to the support and/or intervention, and progress towards meeting the desired outcome.				interventions in place. 90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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
Criterion 1.1.12.2 Consumers are supported to access services within the community when appropriate.	CI	The service has conducted a project on maintaining independence and linking with the community. The residents were assisted to gain their transport card to access public transport. The service organised for staff to assist in gaining the required documents and accompanied the resident to the transport authority to gain the required cards. The analysis of the project records that residents are now able to continue to catch buses and trains for their own personal recreation and access to community activities and events. The residents reported that being encouraged to access public transport has enabled them to maintain their links with the community. The report records positive outcomes in cognition, less intense problems with behaviours, better sleep patterns, good social outlets and avoiding depression has resulted from the residents maintaining their contacts with the community. The residents report that being encouraged with their independence is a real strength of the service which they greatly appreciate.	The achievement of accessing community resources is rated beyond the expected full attainment. The quality improvement project sighted had a documented review process which included analysis and reporting of findings. The projects and activities document evidence of action taken based on findings and have improved resident's connection to public transport and accessing the local community. Resident satisfaction has been measured as a result of the review process, with positive outcomes recorded for the physical and mental health of the residents.

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End of the report.