

Logan Samuel Limited - Anne Maree Gardens

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:	Logan Samuel Limited
Premises audited:	Anne Maree Gardens
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 5 April 2017 End date: 6 April 2017
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:	67



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

Anne Maree gardens provide psychogeriatric, rest home and hospital level care for up to 76 residents. The service is operated by Logan Samuel Ltd and managed by a facility manager and a clinical leader. Since the previous audit there has been a reconfiguration with the addition of four psychogeriatric beds and a reduction of four rest home beds. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, a mental health services professional and a general practitioner.

This audit has resulted in a continuous improvement being awarded as a result of the addition of the new psychogeriatric beds to allow some residents to remain in the facility which has been their home for a number of years.

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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The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a Maori health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring the services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively.

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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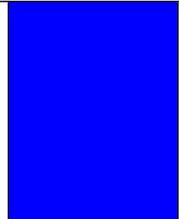
The business and quality and risk management plan includes the goals, values and philosophy of the organisation. Monitoring of the services by the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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.
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The organisation works closely with the local Needs Assessment and Service Coordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and a designated general practitioner. On call arrangements for support are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' records reviewed demonstrated that needs, goals and

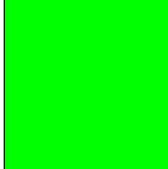
outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. One on one activities are also promoted.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses and care staff all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs being catered for. Policies, procedures and flip charts guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents and family members verified satisfaction with meals provided.

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 facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken offsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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 organisation has implemented policies and procedures that support the minimisation of restraint. Currently there are no enablers or restraints in use at the time of audit and the facility offers a restraint free environment. Policy and processes are in place for comprehensive assessment, approval and monitoring with regular reviews, should any enabler or restraint use be indicated. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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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The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets quarterly. Specialist infection prevention and control advice is able to be accessed from the DHB, laboratory microbiologist and the GP. The infection control programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and procedures and supported with regular education.

Aged care specific infection surveillance is undertaken, with data analysed, trended and benchmarked. Results are reported through to management and staff. Follow-up action is taken as and when 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	1	44	0	0	0	0	0
Criteria	1	92	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>Anne Maree Gardens rest home and hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as verified in the training records reviewed.</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 clinical leader, registered nurse and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. The clinical records reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including consent for photographs, outings in the van, students providing cares, for annual influenza vaccinations, or any treatments/procedures to be performed.</p> <p>Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documentation, where relevant, was in the residents' records reviewed. The clinical leader demonstrated understanding</p>

		<p>and explained situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis during the audit.</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>During the admission process, the residents/family are provided with a copy of the Code, which also includes information about the Advocacy Service. Pamphlets about the Advocacy Service are available. Family members spoken with were aware of this service and how to access this for their relative if requested. Residents are welcome to have support persons of their choice.</p> <p>Staff interviewed are fully informed of how to access the Advocacy Service and examples of their involvement were discussed with the clinical leader.</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>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, trips to the movies and other entertainment.</p> <p>The facility has open visiting hours and encourages visits from residents family/whanau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealing with staff.</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 complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that eight complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The facility manager and the clinical leader are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Families/residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service through the pre-admission and admission process. Information is</p>

<p>Consumers are informed of their rights.</p>		<p>provided in the resident information brochure and the information pack provided on admission. Staff discuss the Code with the family and the individual resident on admission. The Code is displayed in all service areas along with information on advocacy services, and how to make a complaint.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents, families and the general practitioner (GP) interviewed confirmed that services are provided in a manner that has regard for residents' dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff interviewed understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending personal cares, ensuring resident information was held securely and privately, exchanging verbal information in the office and not at the bedside). All residents have their own individual rooms and residents who share rooms have screening provided to ensure privacy is maintained. Residents are able to have their own belongings and an inventory was maintained in each individual record reviewed. There is a diverse range of residents with different ethnicities observed during the audit. Staff accommodate their needs.</p> <p>Residents are encouraged to maintain their independence through participating in community activities, being assisted to external appointments and participation in clubs of their choosing.</p> <p>The care plans and activities plans reviewed documented information related to the individual resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified during the admission process and were documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in individual staff and training records.</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</p>	<p>FA</p>	<p>Staff support the four residents in the service who identify as Maori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into the day to day practice, as is the importance of whanau to Maori residents. There is a current Maori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers and the district health board Maori health advisory team, if required. Guidance on tikanga best practice is available and is supported by staff who identify as Maori in the facility. The two of four Maori residents were able to be interviewed. They and their whanau reported staff</p>

cultural, values and beliefs.		acknowledged and respected their individual cultural needs.
<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	Residents/families verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident`s personal preferences, required interventions and special needs were included in all care plans reviewed. A resident satisfaction survey questionnaire sighted includes evaluation of how well residents` cultural needs are met, and this supported the individual needs are being met.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and all family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and they, or their family member, felt safe. The general practitioner interviewed also expressed satisfaction with the standard of services provided to residents.</p> <p>The orientation/induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in the staff training records reviewed. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through staff education, input from external specialist services and allied health professionals, for example, psychiatric community nurses, physiotherapist, the wound care specialist nurse, dietitian, services for older persons, geriatricians and psychiatrists. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and can access their own professional network to support contemporary good practice. An example of good practice observed during the audit included, the clinical leader interviewed works closely with the general practitioner by completing all medical rounds together. Each resident is reviewed and discussed in full. The clinical leader is currently completing a Masters level degree and is using workplace</p>

		experiences and learning as part of the practicum.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There is also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirement of the Code.</p> <p>The DHB interpreter service is able to be accessed as required on a referral basis. Staff are able to provide interpretation as and when needed and family members are used, as appropriate, for the residents for whom English is not their first language.</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>	FA	<p>The strategic and business plan, which is reviewed annually, outline the values, philosophy, scope, direction and goals of the organisation. The document describes annual and longer term objectives and the associated operational plans. The person/family centred approach is reflected in planning documents. A sample of quarterly reports to the directors showed adequate information to monitor performance is reported including financial performance, emerging risks and issues.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role for 12 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirms knowledge of the sector, regulatory and reporting requirements and attends regular management training and sector conferences.</p> <p>The service holds contracts with the DHB and the Ministry of Health (MoH) for Younger persons with a disability (YPD), respite, long term chronic health conditions, psychogeriatric, and rest home and hospital level services. 67 residents were receiving services under the contract (27 rest home, eight psychogeriatric, 26 hospital level, four YPD residential non-aged care and two long term chronic health conditions) at the time of audit.</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</p>	FA	<p>When the facility manager is absent, the director carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by an RN who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>

<p>manner which ensures the provision of timely, appropriate, and safe services to consumers.</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 organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes, management of incidents and complaints, audit activities, health and safety, regular resident satisfaction surveys, monitoring of outcomes, clinical incidents including infections and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the governance meetings, monthly integrated meetings and all staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, weekly memos and their regular staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed at least annually. The most recent survey showed a request for smaller areas where families and residents could meet and this has been responded to with a number of additional areas set up.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. It is suggested that the facility would benefit from being involved with some benchmarking activity with similar sized organisations and some further streamlining of their policies and procedures.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form which are then managed through the electronic reporting system. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to management and all staff.</p>

<p>family/whānau of choice in an open manner.</p>		<p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.</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>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation, a verbal review following orientation and a performance review after one year.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Three staff members are internal assessors for the programme. All staff have either completed or are enrolled in required education, including dementia care. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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 a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family members interviewed supported this. Observations and review of a two week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24//7 RN coverage in the hospital.</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>The resident's name, date of birth and National Health Index (NHI) unique identifier number were used on labels on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' records sampled for review. The clinical notes were current and integrated with GP and allied health service provider records. Records were electronically maintained and hard copy records were legible with the name and designation of the person making the entry identifiable, for example, the activities co-ordinators records sighted.</p> <p>Archived records are held securely and are readily retrievable when required. Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>CI</p>	<p>Residents enter the service when the required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager and/or nursing staff. They are also provided with written information about the service and the admission process. The organisation seeks updated information from the DHB and the GP for residents accessing respite care.</p> <p>Family members interviewed stated that they were satisfied with the admission process and the information that had been made available to them on admission. Records reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements.</p> <p>A continuous improvement identified for this organisation is the implementation of the psychogeriatric unit which provides psychogeriatric level of care within the facility to ensure the residents concerned can remain in their home (this facility) when they require this level of care.</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>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whanau. At the time of transition between services, appropriate information, including the medication records, behavioural records and management plans and any advance directive is provided for the ongoing management of the resident. All referrals were documented in the electronic progress records reviewed. A transfer was occurring during the audit and this was managed effectively by staff. Safety was considered and family were notified of the</p>

		transfer and the care plan was updated.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Annual competencies are completed and a record is maintained.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on a regular basis and audits are completed six monthly. The GP and the pharmacist ensure reconciliation is performed of all prescriptions on admission to the service.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medication fridge were reviewed and are within the recommended range.</p> <p>Good prescribing practices were verified with the electronic system reviewed and as discussed with the GP. The required three monthly review is consistently recorded. The clinical leader also maintains a schedule for the medication reviews.</p> <p>There are no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner when needed.</p> <p>Any medication errors are reported to the registered nurse and/or the clinical leader. An incident form would be completed by staff. The resident or designated representative are advised. There is a process for analysis of any medication errors, and compliance with this process was verified.</p> <p>No standard orders are used.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>The food service is provided on site by a cook and kitchen hands and is in line with recognised nutritional guidelines for older people. The menu sighted follows the summer and winter patterns</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>and has been reviewed by a qualified dietitian within the last two years. Any recommendations made at the time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service monitors food temperatures, fridge temperatures and all food ordered is checked by the cook on arrival and stored appropriately. The cook is new to this service. All staff in the kitchen have completed food safety and food hygiene training. A flip chart is available to guide staff on all aspects of food service.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. A copy is retained in the hard copy resident's record and a copy is provided to the cook. The personal food preferences, any special diets and modified texture requirements are made know to the kitchen staff and accommodated on the daily menu plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet the resident's nutritional needs, was available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal and those requiring assistance had this provided. There is sufficient staff on duty in the two dining rooms at meal times to ensure appropriate assistance was available to residents as needed. Some residents have their meals in their own room. Family are welcome to assist at the meal times, or if visiting, are offered refreshments.</p>
<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>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whanau/family. Examples of this occurring were discussed with the clinical leader. There is a clause in the service agreement related to when a resident's placement can be terminated.</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>Information is documented using validated recognised nursing assessment tools such as pain scale, falls risk, skin integrity, dietary profiles and depression scales, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by one of the four trained interRAI assessors on site.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress records, activities records, medical and allied health professional's records clearly written, informative and relevant. Behaviour plans are developed and implemented for residents presenting with challenging behaviour and these are evaluated regularly and any changes or alternative techniques required are updated accordingly. Any change in care required is documented and verbally passed on to relevant staff. Residents/family/whanau reported participation in the development and ongoing evaluation of 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>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their identified needs, goals and the plan of care. The attention to meeting a diverse range of resident's individual needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is 'exceptional' and well managed by the clinical nurse manager and care staff. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was readily available, suited to the levels of care and including YPD residents to meet individual residents' needs.</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>	FA	<p>The activities programme is provided by one diversional therapist and two activities coordinators. One activities coordinator is mid-way through the diversional therapy training and one has completed the diversional therapy course and is awaiting the certificate to validate completion of this training. Two coordinators cover the weekend with prepared plans provided by the diversional therapist weekly. A separate programme is developed and implemented for the four YPD residents.</p> <p>Assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matched the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities programme is discussed at the minuted residents' meetings and indicated</p>

		<p>resident/family input is sought and responded to. The service`s satisfaction survey demonstrates satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they enjoyed the programme and outings provided.</p> <p>Activities for the secure dementia and psychogeriatric service are specific to the needs and abilities of the people living in there. Activities are offered for the twenty four hours and at times when individual residents are most physically active and/or restless. This has resulted in the reduced need for medication, improved appetite and improved sleep patterns for some individual residents. Interaction with the rest home and hospital residents is encouraged when residents are able to participate.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress records. If any changes are noted, it is reported to the registered nurse and to the clinical leader.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessments or as residents` needs change. Evaluations are documented by the registered nurse. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples reviewed of short term care plans showed these were consistently reviewed and progress evaluated as clinically indicated. Wound care plans were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>	FA	<p>Residents were supported to access or seek referral to other health and/or disability service providers. Although the service has a resident GP, residents may choose another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP or the clinical leader sends a referral to seek specialist input. Copies of referrals were sighted in residents` hard copy records, including to orthopaedic outpatients, radiology services, diabetes clinic, dentist, podiatry and other services.</p> <p>Referrals are followed up on a regular basis by the clinical leader or the GP. The resident and the family/whanau are kept well informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
Standard 1.4.1: Management Of Waste	FA	Staff follow documented processes for the management of waste and infectious and hazardous

<p>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>		<p>substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 2 June 2017) was publicly displayed. The Certificate of Public Use for the new hospital wing has been extended until 16 June 2017 to accommodate the completion of the new lift.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>External areas are safely maintained and are appropriate to all the resident groups and setting.</p> <p>Residents confirmed and were observed demonstrating they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. The facility is accessible to meet the equipment and mobility needs of the residents.</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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes a majority of rooms with shared ensuites, and a sufficient number of additional toilets and showers throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Bedrooms provide both single and some shared accommodation. Where rooms</p>

<p>Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>are shared approval has been sought and adequate privacy is able to be ensured. Each resident has a call bell. Rooms were personalised with furnishings, photos and other personal items displayed. The new rooms in the psychogeriatric wing are all an adequate size to cater for the residents.</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>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required with new areas recently being developed. Furniture was appropriate to the setting and residents' 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>Laundry is undertaken off site by a contracted provider with a facility to do personal washing if requested. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a designated cleaning team who have received appropriate training. Staff have undertaken appropriate training, as confirmed in interview of cleaning staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</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>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in November 2015; this had been updated from the original plan approved on 27 May 2003, following the completion of the new hospital wing. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 13 February 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures for all groups of residents.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, radios, torches and gas BBQ's were sighted and meet the requirements for the 67 residents. Water storage tanks are located around the complex, and there is a generator on site.</p>

		<p>Emergency lighting is regularly tested.</p> <p>Call bells, which are directed to pagers, alert staff to residents requiring assistance. Call system reviews are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time each night.</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 residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and many have doors that open onto small or large deck areas. Heating is provided by oil fin or panel electric heaters in residents' rooms and also in the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</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 service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection prevention and control is guided by a comprehensive and current infection control manual, with input from the infection control coordinator. Reference resource infection prevention and control material is also available and accessible to staff. The infection control programme and manual are reviewed annually.</p> <p>The clinical leader is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the staff meetings.</p> <p>The IPC committee includes the clinical leader, one registered nurse and a senior caregiver.</p> <p>Signage is available to promote infection prevention and control such as for; hand washing techniques and if visitors are unwell not to visit the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical,</p>	FA	<p>The infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role and has been in this position for approximately four years. The infection control coordinator (ICC) has attended infection control 'boot camp' training, outbreak</p>

<p>and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>management training and 'Bug Control' infection control training as verified in the training records reviewed. Well established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The GP interviewed stated advice can be sought from the contracted medical practice at any time. The coordinator has access to residents' electronic records and diagnostic results to ensure a timely treatment and/or resolution of any infections.</p>
<p>Standard 3.3: Policies and procedures 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>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2016 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good handwashing technique and use of disposable aprons, gloves and hats, when necessary. Hand washing facilities were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. An external contracted infection control service provides updates and relevant infection prevention and control reference information for staff to access and for educational purposes.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions annually. Education is provided by the clinical leader and the registered nurses. Content of the training was documented and evaluated to ensure it was relevant, current and understood. An on-line infection prevention and control training course is also available. A record of attendance was maintained. Separate training is provided for the domestic staff and training for the kitchen staff is centred on food hygiene and food safety requirements. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education had been provided. There have been no outbreaks since the last audit.</p> <p>Education with residents is generally on a one-on-one basis and handwashing is the most important. This is ongoing due to the nature of the services provided.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out</p>	<p>FA</p>	<p>Surveillance was appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. When an infection is</p>

<p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>identified, a record of this is documented in the electronic resident management system/infection reporting form. The IPC Committee reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with the registered nurses at the monthly registered nurse meetings and staff at the staff handovers. Graphs are produced that identify trends for the last month and annually, and comparisons against previous months and years can be reported on. The results are reported to the facility manager.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for any enabler and restraint management in the facility if required and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit there were no residents who were using either restraints or enablers and the facility maintains a restraint free environment.</p> <p>Restraint is only ever used as a last resort when all alternatives have been explored. This was evident from interviews with staff.</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 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate,</p>	CI	<p>Entry to services is clearly documented in policy and understood by the service providers, local communities and referral agencies. All assessments were able to be verified for all residents at this facility in the electronic records reviewed. The service provides a range of services and specialises in dementia care at all levels. The service recognised an increased need to provide psychogeriatric level of care within the facility. After a contract was secured a new unit was established. All staff are fully trained who work in this</p>	<p>Having fully attained this criterion, the service can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings, and improvements to service provision and residents' safety, security and satisfaction as a result of the review. This implementation of the psychogeriatric unit has provided an additional level of care for the residents within this facility. A full cognitive stimulation therapy programme has been successfully implemented. The unit has full occupancy and is continuing to receive referrals from psycho-geriatricians with a recommendation to increase additional beds to meet this demand. A sensory area has been created for the residents which is proving to be successful in creating a calming space for de-escalating behaviour. Outcomes for staff have been positive, and with additional training, staff are more qualified and confident working with the residents, especially those who exhibit difficult behaviour as a result of declining abilities or dementia. Staff interviewed are learning to manage and respond to individual behaviours, identify strengths and weaknesses and maintain or maximise opportunities for residents to retain abilities and social connections, through participation in daily activities. Family members reported that their family members are well managed, are calmer, and there is excellent</p>

<p>local communities, and referral agencies.</p>		<p>unit. The unit is fully supported by psycho-geriatricians from the DHB. The service is well recognised by the referral agencies as was confirmed by a visiting community nurse and the GP who were interviewed during the audit. They provided positive feedback about the service, entry criteria and the entry screening processes.</p>	<p>communication from the staff who are very attentive to meeting the residents` needs. Residents are able to socialise with other residents from the rest home and hospital when they are participating in activities together. Feedback from family members interviewed confirmed appreciation that their family members did not require a further transfer, additional stress or change that would cause them to be more distressed. The benefits for individual residents is that they are now able to be reassessed and remain at this home, or be transferred for this level of care from the DHB or other services.</p>
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End of the report.