Avonlea Dementia Care Limited

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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:	Avonlea Dementia Care Limited
Premises audited:	Avonlea Dementia Care
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 16 September 2015 End date: 17 September 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 52

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

Dementia Care New Zealand Ltd is the parent company of Avonlea Dementia Care and cares for up to 65 residents requiring hospital (geriatric), hospital (psychogeriatric) and rest home (dementia) level care. On the day of the audit there were 52 residents. The manager is well qualified and experienced for the role. Relatives and the general practitioner (GP) interviewed spoke positively about the service provided.

The audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents' and staff files, observations and interviews with relatives, staff and management.

The one shortfall identified at the previous audit relating to completion of building renovations, has been addressed.

This audit has identified improvements required around registered nursing cover, care interventions including wound management and medication storage. The service continues to exceed the required standard around activities and the quality improvement programme.

Consumer rights

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

The service ensures effective communication with all stakeholders including residents and families. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Avonlea has a quality and risk management system in place. Key components of the quality management system link to relevant facility meetings. The service is active in analysing data, with evidence of benchmarking outcomes with other similar aged care facilities. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme, which provides new staff with relevant and specific information for safe work practice. The staffing levels for caregivers provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurses are responsible for care plan development with input from family. Relatives interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and families advised satisfaction with the activities programme. Medications are prescribed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

The building holds a current warrant of fitness.

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.

Avonlea has a philosophy to actively minimise the use of restraint. A restraint policy includes comprehensive restraint procedures and aligns with the standards. There are six residents using restraints and no residents using enablers.

Infection prevention and control

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

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	2	11	0	1	2	0	0
Criteria	3	33	0	1	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures have been implemented and residents and their family/whanau have been provided with information on admission. Complaint forms are available at the service. Staff interviewed (six caregivers (one from the psychogeriatric home, one from the hospital and one from each of the dementia homes), two registered nurses, three diversional therapists in training and the clinical manager) were aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Systems and processes have been in place and documented to confirm that all complaints received are managed and resolved appropriately. Family members interviewed advised that they are aware of the complaints procedure and how to access forms. There is written information on the service philosophy and practices particular to the dementia homes included in the information pack.
Standard 1.1.9: Communication Service providers communicate effectively with	FA	All residents in the hospital have dementia; therefore, no residents were interviewed. Four family members (two from the dementia home, one from the hospital and one from the psychogeriatric home) interviewed stated they are informed of changes in health status and incidents/accidents. This is confirmed on the 10 incident forms sampled. Family members also stated they and residents were welcomed on entry and were given time and explanation about services and procedures. The operations manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The

consumers and provide an environment conducive to effective communication.		service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Dementia Care New Zealand Ltd is the parent company of Avonlea Dementia Care. The service provides care for up to 65 residents requiring hospital, psychogeriatric and secure dementia (rest home) level care. On the day of the audit, there were eight residents at hospital level care, eight in the psychogeriatric home and 36 in the three secure dementia homes. The operations manager has worked for Dementia Care New Zealand for 11 years and in this role for five years. She is supported by a clinical manager, who is a registered nurse and has been in this role for 18 months. The current business plan has been implemented including a number of actions with timeframes for the service. The operations and clinical managers have completed more than eight hours training related to managing a rest home and hospital in the past year.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	CI	The organisation wide risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the quality meeting. All quality data is logged and monitored by the operations manager and clinical manager. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes sighted have included actions to achieve compliance where relevant. Discussions with staff confirmed their involvement in the quality programme. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2015 is being completed. Areas of non-compliance identified at audits, have had corrective action plans developed and signed as completed. Benchmarking with other facilities occurs on data collected. The service has implemented a health and safety management system. There are implemented risk management and health and safety policies and procedures in place, including accident and hazard management. The service has comprehensive policies and procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. A death/Tangihanga policy and procedure outline immediate action to be taken upon a resident's death. Falls prevention strategies are implemented for individual residents. Relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to staff and families.
Standard 1.2.4: Adverse Event	FA	Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Two appropriate notifications have been made to the DHB and HealthCERT. A sample of resident related incident reports for

Reporting 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.		September 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with other facilities.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 10 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. The orientation programme is relevant to the dementia home and includes a session on how to implement activities and therapies. Annual appraisals are conducted for all staff. A completed in-service calendar for 2014 exceeded eight hours annually and the 2015 in-service programme is being completed. The clinical manager and registered nurses are provided with ongoing training relevant to the roles within the wider group and through the DHB. There are 34 caregivers. Thirty-two have completed the required dementia standards. Two who have not yet worked at the service for 12 months are enrolled in the course. All of the activities staff have completed dementia related training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably	PA Low	Avonlea has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents. The clinical manager (a registered nurse), works full time Monday to Friday. In addition, there are two registered nurses on duty (one based in the hospital and one in the psychogeriatric unit), on both morning and afternoon shift. There is one registered nurse in the building overnight. There are registered staff available on site or on call 24 hours per day. Caregivers and family interviewed advised that sufficient staff are rostered on for each shift. There is a staff member on duty that has been trained in first aid at all times.

qualified/skilled and/or experienced service providers.		
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The service uses individualised robotic sachets which are checked in on delivery by two registered nurses. A registered nurse was observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements except eye drops which were not all dated when opened and two expired medications were stored in the stock cupboard. The medication fridge is maintained in a safe temperature range. Ten of 10 medication charts were reviewed three monthly with medical reviews by the attending GP. Resident photographs were on all 10 medication charts reviewed and all as required medications had a documented indication for use. An annual medication administration competency is completed for all staff administrating medications and medication training had been conducted. There were no residents who self-administered medications. Individually prescribed medication charts are in use and this provides a record of medication administration information.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All meals at the service are prepared in a well-appointed kitchen and cooked on site by the cook. There is a rotating winter and summer menu, which has been reviewed by a dietitian. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. The service records all fridge and freezer temperatures daily. Staff were observed serving and assisting residents with their lunchtime meals and drinks. Diets are modified as required. Food services staff know resident dietary profiles and likes and dislikes and any changes are communicated to the kitchen via the registered nurses. Six monthly nutritional assessments are completed for all residents and more frequently if required. Supplements are provided to residents with identified weight loss issues. Resident meetings allow for the opportunity for resident feedback on the meals and food services generally. Family members interviewed indicated satisfaction with the food service. Food and snacks are available in all homes at all times.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their	PA Moderate	Short-term care plans, turning charts, food and fluid records and behaviour monitoring charts were evident. One of two residents requiring two hourly turns did not have these documented. In all files sampled, the residents are receiving care that meets all their needs. Dietitian's instructions were not documented in all of the sample of care plans. Other care plans documented interventions for all identified needs. The GP interviewed stated the facility applied changes of care advice immediately and was complementary about the quality of service delivery provided. Residents' needs are assessed prior to admission and resident's primary care is provided by the facility GPs unless the resident chooses another GP.

assessed needs and desired outcomes.		Dressing supplies are available and a treatment room is stocked for use. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed. There were seven wounds at the facility at the time of the audit including four pressure areas (two for one resident). Not all wounds had documented assessments, management plans and review timeframes. There was evidence in files of the wound specialist referrals.
Standard 1.3.7: Planned Activities 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.	CI	There are two diversional therapists and four trainee diversional therapists with one primarily based in each home. Activities are provided over seven days. The programme is planned monthly and a copy is placed on the notice board. An activity plan is developed for each individual resident based on assessed needs. The activity plan is reviewed at least six monthly along with the residents nursing care plan. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. The service uses a van for resident outings. Residents were observed participating in activities in all homes on the day of audit. Resident meetings provided a forum for feedback relating to activities. Family members interviewed discussed enjoyment of residents in the programme and the diversity offered to all residents. The service continues to exceed the standard around the activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. In the files sampled, short-term care plans are utilised and any changes to the long-term care plan were dated and signed. All care plans reviewed were evaluated within the required time frames.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical	FA	There is a current building warrant of fitness, which expires on 1 June 2016. The service provides a safe environment. The previous partial provisional audit identified that renovations had not been completed in the psychogeriatric home. These are now completed. The previous finding has now been addressed.

environment and facilities that are fit for their purpose.		
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections, based on signs and symptoms of infection. All infections are individually logged, monthly. The data has been monitored and evaluated monthly and annually and is benchmarked by an external provider.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Avonlea has a philosophy to actively, minimise the use of restraint. A restraint policy includes comprehensive restraint procedures and aligns with the standards. There are six residents using intermittent restraints and no residents using enablers.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	The service has an 11 bed psychogeriatric unit, a 10 bed hospital unit, an eight bed dementia unit, a 16 bed dementia unit and two 10 bed dementia units. All are in the same facility. There is a registered nurse based in the psychogeriatric unit, another based in the hospital during the morning and afternoon shifts, and one registered nurse covers the facility overnight. As there are currently over 50 residents in the facility (53), the service does not meet the ARHSS contract in regards to sharing of staff between 10pm and 7am.	There is one registered nurse on duty to cover both the hospital and the psychogeriatric unit overnight. The registered nurse on duty overnight is rostered in the psychogeriatric unit and oversees the hospital as needed.	Ensure that registered nursing cover meets contractual requirements for the hospital and psychogeriatric units. 90 days
Criterion 1.3.12.1 A medicines	PA Moderate	There are four medication rooms and medications are stored in these rooms. Imprest stock medication is maintained. Expired medications were found in the stock storage cupboard. All stocks of prescribed	There were expired medications stored in the stock medication	Ensure that all expired medications

management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		medications are kept in the treatment room for that resident. Not all eye drops had been dated when opened.	cupboard. One bottle of eye drops and one tube of eye ointment had not been dated when opened.	are returned to the pharmacy and that all eye drops and eye ointments are dated when opened. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	All residents have individualised care plans. A dietitian sees residents promptly when unintended weight loss is identified. Four of six care plans sampled had dietitian instructions documented. It is noted that the cook and caregivers were aware of both interventions and these were seen to be implemented. One pressure area (of four) had a comprehensive wound assessment and review documented. All wounds had ongoing dressings documented as they occurred, but no documented ongoing management plan. Four of seven wounds document 'PRN' for the review timeframe, with no specific instruction for when review should occur. The other three wounds have been reviewed in the stated timeframe. One pressure area had no documented assessment (or management plan as above) and documented PRN for the review timeframe. There was evidence of ongoing review. Two resident files sampled required two hourly turns as documented in the care plan. The turns were documented as occurring for one of these residents.	One of seven wounds at the facility (a pressure area) did not have a documented assessment. Two further (of four) pressure areas did not have the grade documented on the wound assessment and evaluation form. The wound assessment and evaluation form and wound schedule form used does not have an area to detail the management plan for the wound Four of the seven wounds at the facility (including one pressure area) state PRN for the	Ensure all wounds have a documented and comprehensive assessment, management plan and specific timeframe for review. Ensure two hourly turns are documented as occurring. Ensure dietitian's instructions are reflected in

			review time but no specific timeframe. One of two files sampled where the resident required two hourly turns (from the psychogeriatric home) did not have these documented as occurring (although staff could describe completing regular turns). Two resident files sampled (one from the dementia home and one from the psychogeriatric home) did not have dietitians instructions reflected in the care plan.	care plans. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The service has a quality programme that is implemented in practice. Quality improvement data is analysed to identify trends and themes. This includes incidents, infections, hazards, audits and complaints.	Quality data gathered continues to include comprehensive templates to identify trends, actions and identification of resolution. Internal audits include quality improvement (QI) plans when service shortfalls are identified. The QI plans include identified problem, action and ongoing evaluation of action undertaken. Audit results are collated and documented. Results are then fed back to staff at appropriate forums, (eg, staff and health and safety meeting). Meeting minutes reflect a culture of quality improvements and ongoing review of practice. Quarterly external benchmarking analysis, that includes outcomes, is completed. Residents and family are provided with quality feedback and initiatives through newsletters and meetings. The quality meeting includes a discussion of new quality improvements, unresolved/outstanding quality improvements. The service is proactive in identifying QIs on an ongoing basis and monitoring these until signed out as completed. The May 2015 clinical indicator analysis and outcomes report identified that skin tears were above the standard benchmark for the hospital. A QI plan was developed and staff were reminded at handovers about skin integrity checks and early reporting and a review of all residents at risk due to poor skin integrity occurred. There were no reports of skin tears in the hospital in June. QIs are also developed around managing specific resident behaviours.

		The service continues to maintain the quality programme and improve on areas of service delivery. Staff are knowledgeable about quality processes. Meeting minutes reviewed include registered nurse; quality committee; infection control; health and safety; and internal management. Minutes reviewed document the discussion of all quality activities. The service has an internal audit schedule that is implemented. Internal audits are completed	

		and actions identified.	
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	CI	A process is implemented to measure achievement against goals in the strategic business plan and quality and risk management plan. Formal review takes place six monthly. Avonlea holds monthly quality meetings, weekly internal management meetings, monthly registered nurse meetings, home managers' meetings and the operations manager reports monthly to the directors of Dementia Care	The service continues to be proactive in monitoring outcomes from their quality management programme through meetings, and quality reports and through their vision and values and the impact on family through the family focus group. Reports provided to the monthly quality meeting include clinical manager/RN monthly report, education coordinator monthly report, quality and systems manager monthly report, activities team monthly report, marketing monthly report, and home managers' report. Ongoing quality improvements are monitored through all meetings and annual goals are evaluated. The family focus group meeting is held annually (last 2 February 2015) with one director and four participants. An action plan was completed as a result of areas family members would like to improve.

		NZ. Internal audits are completed and include the identification of any issues and corrective actions where required. Corrective actions are discussed at the monthly quality meetings and monthly staff meetings and the service ensures that all corrective actions are followed through and signed off. Incidents, accidents, hazards, complaints, infections, education, activities, marketing, quality systems and restraint are monitored through the	

		monthly quality meetings. Monthly internal benchmarking of the service in areas (but not limited to): resident accidents and infections and staff accidents are used to measure the effectiveness of the objectives of the quality and risk management plan. Resident meetings occur monthly in the dementia home and the hospital home and an annual family focus group is held.	
Criterion 1.3.7.1 Activities are planned and	CI	The programme reflects residents'	The diversional therapy (DT) plan continues to be a key part of the overall long term care plan and the service continues to be pro-active in providing a meaningful programme. The programme is regularly reviewed with family and is extensive across the day. Interview with three activities staff noted that they are committed to working with residents and families and described how they had

provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.		interest in the environment as appropriate to dementia care and they have choice in their level of participation. The activity staff complete individual assessments on resident admission, this is documented on the activities profile sheet, which is then used to develop the 24 hour activities care plan. Families are involved in the activity plan and provide information on the residents past and current interests and social profile.	developed good connections with residents and have got to know them. Activities are based on the 'Best friends' approach to care. Staff have attended a "best friends" course and are now doing a refresher "come into my world". A range of activities are available for residents to choose from, with staff spending a large proportion of their time with 1 on 1 interaction with the residents. Activities provided are individualised to the needs of the resident in the varied homes and are intentionally planned. Examples included the three month trial of a number of dementia specific resources in April 2015. Following the trial report dementia specific activities resources relevant to different stages of the dementia process where purchased and are now used by activities staff and caregivers to engage residents. One activities staff member is a trained massage therapist and provides one to one hand massages with residents as this has been shown to be effective in relaxing and calming residents and the residents often engage in meaningful conversation and expresses concerns during the massage. The service actively engages residents in baking, as this is an activity in which most women of the generation had commonly experienced. The residents are very involved in the baking. There is an annual bake off competition which residents are reported by family and staff to have very much enjoyed. This was intended to reflect 'fairs' and 'shows' of the resident's generation where baking competitions were common. Following this year's bake off weekly baking groups occur on a Thursday with a café club occurring each Wednesday during which the previous days baking is consumed. Physical capabilities are considered in the delivery of the activities programme and there is a greater proportion of their time with 1 on 1 interaction with the residents. Everyday life activities are included in the programme for the residents within the homes such as folding laundry, household chores, walks in the garden and exercises. Staff interviewed advised that household chores are voluntarily undertaken by residents within their small homes. There are visiting musical entertainers and sing-a-longs. There are as well as expressive programmes such as sing-a-longs and entertainers. Theme days, movies and happy hour is included into the programme as well as birthday celebrations and festive or special events. The DT's contribute news and interesting/upcoming events for the facility newsletter. The design of the homes ensures that a homely, family environment is in place to assist with normalising the service and provide activities in a calm environment. There are many seating nooks and quieter areas for residents who choose not to participate in group activities. There are weekly van outings which include farm animal visits. Resident outing risk assessments are completed by the DT's. Two staff (includes driver) go on every outing or van drive. All DT's have a first aid certificate. There are community visits such a shopping trips, picnics, feeding ducks and walks in the park. Family are encouraged to join in the activities programme. Families interviewed (hospital) report that they are involved and can join in activities.

End of the report.