

# Metlifecare Limited - Metlifecare Somervale

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Metlifecare Limited
<b>Premises audited:</b>	Metlifecare Somervale
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 25 May 2016    End date: 26 May 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	38

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Metlifecare Somervale is one of 26 facilities owned and operated by the Metlifecare group, nine of which have care facilities. Metlifecare Somervale provides rest home and hospital level care for up to 40 residents. There is a village on the same site; this was not subject to this audit.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management, staff and a general practitioner. Feedback from residents and families/whānau members was positive about the care and services provided.

This audit has resulted in three areas of continuous improvement related to the activities programme, quality data and follow-up of corrective actions. There are two areas requiring improvement related to prescribing of medicines by the general practitioner (GP) and policies not being up to date.

## 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 residents receive services that respect their rights. Staff demonstrated knowledge and awareness of their obligations related to consumer rights legislation. The residents are treated with respect and dignity and are not subject to abuse, neglect or discrimination. All rooms are single occupancy to maintain residents' privacy.

There are appropriate processes and procedures implemented to ensure residents who identify as Maori, or any other culture, have their individual beliefs respected and acknowledged. If required, the service can access an interpreter. The service provides an environment that encourages good practice, which includes evidence-based practice.

Residents and families receive full and frank information and open disclosure from staff. The resident, their families or enduring power of attorneys (EPOAs) are involved in the care planning, decision making and consent processes. Where there is an advance directive, the staff act on the decisions. There are no set visiting hours and residents have access to visitors of their choice. All visitors commented on the welcoming nature of the service.

The service has a documented complaints management system implemented. There are no outstanding complaints at the time of audit.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Metlifecare Limited's governing body ensures that business and strategic planning is in place to cover all aspects of service delivery. This is reviewed and updated annually. Metlifecare Somervale has an annual business plan which is personalised to the services offered and strategic goals reflect organisational planning outcomes. Quarterly reporting against the business plan and monthly management reports inform head office of progress with each goal. The village manager is responsible for the overall management of the facility and the nurse manager, who has been in the position for two months, oversees all clinical matters. The nurse manager is a registered nurse with 17 years' experience in aged care.

At organisational level there is a clinical governance group to oversee any issues that occur and to provide oversight of all major clinical projects. At facility level the quality and risk system and processes support effective, timely service delivery. Corrective action planning is implemented to manage any areas of concern or deficits. The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and family/whānau, as appropriate.

Policies and procedures are managed at organisational level. Not all policies have been updated. Record management meets the requirements of the standards. There is no resident information that is accessible to public.

Interviews with staff, management, residents and family/whānau were positive about services offered. This is supported by the 2015 satisfaction survey results sighted which gained 100% for overall satisfaction.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The entry requirements for rest home and hospital level of care are clearly documented. Residents and families receive accurate information on admission to the service. If a bed is not available, a waiting list is maintained. If a potential resident is not able to be admitted a record is maintained and the potential resident and/or their family/whānau are informed.

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

Referral to other health or disability service providers is appropriately facilitated by the general practitioner or registered nurse. There is an appropriate process and risk assessments to facilitate any discharge or transfers to other providers. The service provides a planned activities programme to develop and maintain skills and interests that are meaningful to the residents. There have been a number of quality projects implemented in relation to the programme.

There are processes in place for safe medicine administration. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage. The families and residents report satisfaction with the meal services. The menu has been reviewed and is suitable for residents living in long term care.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented emergency management response processes which are understood and implemented by the service providers. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The care facility has a current building warrant of fitness and the service has an approved fire evacuation plan. Medical and electrical equipment is checked at least annually to meet legislative requirements.

Documentation sighted and interviews with residents and family/whānau confirm that the facilities meet residents' needs with the provision of appropriate furnishings, dining and areas for relaxation. All bedrooms are single occupancy with toilet and hand basin ensuites. The service has a preventative maintenance plan in place and undertakes ongoing reactive maintenance. The facility is appropriately heated and ventilated. The outdoor areas provide suitable furnishings and shade for residents' use.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. At the time of audit there is no restraint or enablers in use. Restraint approval and assessment processes are known to staff. Staff undertake education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraints and how to safely manage both.

## Infection prevention and control

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

Surveillance for infections is conducted monthly. Results of surveillance are collected, collated and analysed to identify any trends and prevent or minimise further infections. The infection control data is benchmarked with other Metlifecare services monthly and external benchmarking occurs three monthly.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	42	0	1	1	0	0
<b>Criteria</b>	3	88	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility. Staff demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents' rights.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The residents' files reviewed had consent forms signed by the resident or their next of kin/enduring power of attorney (EPOA). The files contained copies of any advance care planning, advance directives and living wills that record the resident's wishes for end of life care. Staff acknowledged the resident's right to make choices based on information presented to them.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The residents and family/whanau reported that they were provided with information regarding access to advocacy services. Contact details for the Nationwide Health and Disability Advocacy Service is listed in the resident information booklet. Education on advocacy and support is conducted as part of the in-service education programme.

<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>	<p>FA</p>	<p>There are no set visiting hours and visitors are encouraged to visit. The residents and families reported that the service is 'like a second family' and feel very welcomed to visit. Residents are supported and encouraged to access community services with visitors and the facilities within the wider retirement village complex.</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>	<p>FA</p>	<p>Metlifecare Somervale implements organisational policies and procedures to ensure complaints processes which reflect a fair complaints system. All complaints are registered at Metlifecare head office electronically. Residents, family/whānau and staff reported during interview that they understand the complaints processes in place and are aware of where to find written complaints forms.</p> <p>The service has a complaints register which identifies the nature of the complaint, the date received and the actions taken to address the complaint. Documented complaints information is used to improve services as appropriate. Complaints are a standing agenda item for all meetings including management and staff meetings as confirmed in meeting minutes sighted. All complaints have been managed at a facility level since the previous audit.</p> <p>There were no outstanding complaints at the time of audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The Code is discussed with residents and family/whānau at the time of admission and information is also available in the information booklet. Information on the Code is reinforced at resident meetings. Information is displayed about the Nationwide Health and Disability Advocacy Service. The residents and family reported no concerns about the staff not respecting the resident's rights. All families had high praise for the way that the staff treat and interact with their family member.</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>All rooms are single occupancy. The residents have a privacy sign that they put on their doors that indicates that staff cannot come into their bedroom unless they are invited to enter by the resident.</p> <p>The residents' files reflect that care is provided that is responsive to the individual cultural and spiritual needs of each resident. The services are planned so the residents can maintain as much independence as possible. The family/whānau reported satisfaction with the care provided</p>

		<p>and have no concerns about abuse or neglect.</p> <p>Staff demonstrated knowledge on identifying any suspected abuse and know who to report to if they suspect abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The managers reported that there were no barriers to Māori residents accessing the service. There are no residents who identify as Māori at the time of audit, though there have been Māori residents previously. Staff demonstrated knowledge of the importance of whanau in the care and support of residents who identify as Māori. The service has an iwi referral form and iwi contact numbers. There is a Maori health plan that provides guidance on Tikanga. This plan has been reviewed by a Māori staff member. There is resource information available to staff and internal audits have been conducted on cultural safety.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The resident's individual cultural values and beliefs are recorded in the care plans. All files evidence the care was developed in consultation with the family. The family/whanau reported that the service meets the individual needs of their relatives. Staff demonstrated knowledge in respecting and meeting the individual cultural needs, values and beliefs of each of the residents.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff individual employment contracts have information on professional boundaries. The orientation and induction programme includes staff education on maintaining professional boundaries. The residents and family/whanau report they have no concerns about discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice was observed, promoting and encouraging good practice. Examples included policies and procedures that are linked to evidence-based practice, regular visits by the GP, links with the local mental health services and palliative care services and a number of quality improvements are implemented (also refer to continuous improvement ratings at 1.2.3 and 1.3.7). There is regular in-service education and staff access external education that is focused on aged care and best practice. This included pressure area prevention and reviewing the use of psychotropic medications. Staff reported that they are satisfied with the relevance of the education provided. The residents and family/whanau expressed high satisfaction with the care</p>

		delivered.
<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>The service promotes an environment that optimises communication through the use of interpreter services as required. Staff education has been provided related to appropriate communication methods. The service has not required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Documentation of open disclosure following incidents/accidents was evident.</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 organisation's philosophy, mission statement and values are clearly documented. As required to meet policy, Metlifecare Somervale has a personalised business plan which is in line with the direction and objectives of the organising body as identified in the organisation's operating plan and five-year strategic plan. The business plan identifies how services are planned to address residents' needs. Documented annual goals are reported against quarterly to the organisation's board of trustees. The nurse manager presents a monthly report which includes quality data information.</p> <p>On the days of audit there were 25 hospital and 13 rest home level care beds occupied.</p> <p>The management team consists of the village manager who has been in the role for over nine years and the nurse manager who has been in the role for two months. The nurse manager is responsible for services and care delivery within the care unit. She is a registered nurse with a current practising certificate. Both managers have experience and qualifications related to the roles they undertake and ongoing education is attended. The organisation's clinical quality and risk manager represented the organisation on the days of audit.</p> <p>Interviews with residents and family/whānau confirmed that their needs were met by the service. The resident satisfaction survey results show that for the 2015 resident satisfaction survey results gained a 100% rating for overall satisfaction with services provided. No negative comments were received during interviews with family/whānau, residents or staff on the days 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 manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>Metlifecare Somervale adhere to organisational policy requirements to ensure the day to day operation of the service is managed in an effective manner at all times. Provision of timely, appropriate and safe service to residents is maintained during a temporary absence of a staff by succession planning and assistance from the organisation's head office. There have been two nurse managers and two interim nurse managers (staff who work for Metlifecare) since the previous audit. The clinical quality and risk manager has overseen all required processes to ensure services have not been disrupted.</p> <p>Interviews with staff, residents and family/whānau confirm that it has been 'business as normal' but that they are very happy a permanent nurse manager is now in position.</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>PA Low</p>	<p>The service has a quality and risk management system which was understood and implemented by service providers. This includes the development and update of policies and procedures at organisational level, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. The facility is restraint free. Not all policies sighted are up to date but there is a process in place to manage this at head office and all updated policies are sent to the service and a process is in place to ensure all staff are aware of any changes.</p> <p>The annual operating plan for Metlifecare Somervale includes quality objectives with progressive measurement processes identified. Quality data collected are analysed at facility and governance level. Results are trended and benchmarked against previously collected data and the eight other care units. At facility level this information is used to inform ongoing planning of services to ensure residents' needs are met. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Quality data analysis processes and corrective action planning are shown to generate projects which are clearly documented. The achievement of both the before mentioned areas are rated beyond the expected fully attainment as resident safety or satisfaction has been measured and shows positive results have been achieved.</p>

		<p>Actual and potential risks are identified and documented in the hazard register and in the quality and risk plan. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes which are taken to the two monthly health and safety committee meetings and any required follow up is monitored.</p> <p>Staff, resident and family/whānau interviews confirmed any concerns had been fully addressed by management. Quality improvements are documented and the corrective action process can be followed from the time an issue is recognised until it is implemented, reviewed and closed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Adverse event reporting as identified in policy is implemented by the service. The nurse manager confirmed her awareness of the organisation's requirement related to statutory and or/regulatory reporting obligations including pressure injury reporting to meet documented protocol.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required. Follow up actions are reported on the incident and accident forms. This is confirmed in the incident and accident forms sighted in residents' files. All incident and accident forms are reviewed by the nurse manager.</p> <p>Interviews and documentation sighted confirmed family/whānau are notified of any adverse events or concerns staff have about residents.</p> <p>Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated. (Refer comments in criteria 1.2.3.8).</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>	FA	<p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. This is reflected in the eight staff files reviewed. All roles have job descriptions that describe staff responsibilities. Staff complete an orientation programme with specific competencies for their roles. Not all completed orientation/competency booklets could be located in staff folders. For the files without the booklets there is a signed certificate from the manager to state all orientation processes had been</p>

		<p>completed. This was discussed at the time of audit and the current nurse manager will use a consistent method of recording orientation/competencies. Documentation in the staff files reviewed confirmed some competencies, such as medication management are repeated annually. Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis.</p> <p>The education calendar sighted identifies that staff undertake training and education related to their roles. Topics covered in annual training and education relates to age care and health care services. The education calendar is set at head office and Metlifecare Somervale add additional items as required to ensure staff interests and needs are met. For example, percutaneous endoscopic gastrostomy (PEG) feeding training. Members of the management team also attend workshops and seminars specific to management related topics. Education occurs both on and off site.</p> <p>Resident and family/whānau members interviewed, identified that services are delivered in a professional manner to meet all their needs.</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>Policy identifies staffing levels and skill mix are maintained via the use of a 'staffing level planning tool' to meet residents' needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty to provide safe and quality care.</p> <p>Staffing numbers are analysed at head office to ensure the number of staff on each shift is adequate to meet resident needs depending on care levels.</p> <p>A review of six weeks rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Staff reported that they are able to cover nearly all shifts themselves and that very little use of bureau nurses is required. This allows resident care continuity. Residents interviewed stated all their needs have been met in a timely manner.</p> <p>Two activities coordinators work 39.5 hours per week between them. There are dedicated kitchen, laundry and cleaning staff seven days a</p>

		week. There is a night porter who works seven nights a week from 11 pm to 6 am who responds to any village call bells to ensure there are always a minimum of two staff on the floor in the care unit. Monday to Friday there is an administrator and a secretary who each work 40 hours per week.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files identified that information is managed in an accurate and timely manner. Health information was kept in secure areas in the staff area and these were not accessible or observable to the public. There was no private information on display in the facility. All records pertaining to individual residents demonstrated they are integrated. The archived records are securely stored onsite. Some of the resident's progress notes have entries each shift and recorded the staff member's signature or initial. The service has identified and implemented actions (sighted in staff meeting minutes and interviews with staff) to ensure that the staff also consistently record their name and designation as well as their signature. A signature verification log is also kept. As the service has already commenced making improvements to this, a corrective action has not been given as a systemic issue was not identified.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The nurse manager oversees entry to the service. The enquiry form records all enquires and if the potential resident has an appropriate assessment for rest home or hospital level of care. The resident information handbook contains accurate information about the service. All residents' files contain an appropriate needs assessment for rest home or hospital level of care. The service updates any vacancy on the Eldernet website each weekday.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	When admission has been required to the acute care hospital, the service utilised the DHB's transfer forms. The referral process documented any risks associated with each resident's transition, exit, discharge, or transfer. This included expressed concerns of the resident and family/whānau and a copy of any advance directives. Along with the transfer form, the RN reported that the service also provides a copy of any other relevant information.
Standard 1.3.12: Medicine Management	PA	The service has a prepacked medication delivery system in place. The

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>Moderate</p>	<p>storage, review, administration and disposal of medication complies with required guidelines. Not all of the medications evidenced appropriate information in the prescribing of the medication on the medication chart. The GP conducts medicine reconciliation when residents are admitted to the service and at least three monthly thereafter. Medicine file reviews showed that each medication was individually signed. The controlled drug storage, register and administration met requirements.</p> <p>There were no residents self-administering their medications at the time of the audit. There are policies and procedures if a resident is assessed a competent to self-administer their own medications. There are no standing orders at this facility.</p> <p>The RNs responsible for medication management have all completed medication competency validation and on-going education relating to medication management. The service is in the process of reviewing the medication competency system as they move towards a cloud based medication management system.</p> <p>The service implements reconciliation processes which include the checking of all pre packed medications for accuracy by the RN when delivered to the facility.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a four-week rotational menu that has summer and winter variations. The menu is used across all the Metlifecare facilities. This menu has been reviewed by a dietitian within the last six months. Residents with specific nutritional needs have these met. The kitchen staff get a copy of the nutritional requirements for each resident. Residents are routinely weighed monthly, or more frequently if there is a clinical need. Nutritional supplements are available to residents assessed as requiring these.</p> <p>The kitchen services are based on the food safety principles. There are appropriate processes in place for the purchasing, preparation and disposal of food that complies with current legislation and guidelines. The kitchen staff (and a resident who volunteers in the kitchen) have food safety training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk</p>	<p>FA</p>	<p>The household manager reported the service does not decline entry to a potential resident, if they have an appropriate needs assessment and</p>

<p>to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>there is a bed available. When there is not a bed available, a waiting list is maintained. If the service is not able to admit the resident, the referrer, prospective resident and family are informed of the reason why, with this recorded on the enquiry form and register.</p> <p>The admission agreement is developed through an aged care association that is then personalised to the service. The agreement has clauses on the change in level of care process when the service can no longer meet the needs of the resident. As the service only provides rest home and hospital care, residents assessed as requiring secure dementia care are reassessed and referred to a service that is better able to meet the higher level of need. The service has had occasions where residents have been required to transfer to a service providing dementia or psychogeriatric level of care.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The assessments and reassessments are conducted using the electronic interRAI assessment process. All files had an initial interRAI assessment. The service also uses their own paper based assessments for additional needs that are identified through the assessment process, this includes behaviour assessments, nutrition, falls, wound assessment, pressure injury risk. There is a summary of the assessed needs of the resident and these are then documented on the care plan. The files record and residents/families report that the care provided meets the resident's needs.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The service has an electronic format for the nursing care plans. A copy of the care plan is printed and maintained in the resident's file. The care plans are based on the outcomes from the assessments and the identified needs of the resident. The care plan format includes the resident's specific needs, goals/aims and staff interventions required to address those needs. The care plans evidenced the residents or family consultation and input into their planning. The residents and family/whanau reported satisfaction with the care provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The provision of services and interventions are consistent with meeting the needs of the residents. The resident's records are individualised and personalised to meet the assessed needs of the resident. The care was observed to be flexible and focused on promoting quality of life for the residents. Residents and family/whanau reported satisfaction with the</p>

		care and service delivery.
<p><b>Standard 1.3.7: Planned Activities</b></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>	CI	<p>The service has gained a continuous improvement rating for the quality improvements implemented to ensure the planned activities are meaningful to the resident. The overall planned activities for residents included meaningful activities at the care facility and access to the recreational facilities in the wider retirement village. There are activities coordinators Monday to Friday and care and volunteers assist with the planned and diversional activities over the weekend. The activities staff reported that they gauge the response of residents during activities and modified the programme related to the response and interests. The activities are modified according to the capability and cognitive abilities of the residents.</p> <p>The activities programme covers physical, social, recreational and emotional needs of the residents. The residents were observed to be participating in meaningful activities both inside the grounds of the service and in the retirement village. The residents and families reported overall satisfaction with the level and variety of activities provided. Residents were observed to be going offsite with family/friends.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The organisational policy records that evaluations are conducted at least six monthly and are recorded on the care plan evaluation tool. Eight of the nine resident files reviewed documented an evaluation of the nursing goals and interventions within the past six months. The one remaining file (of one of the residents reviewed in detail) did not evidence an evaluation on the care plan evaluation form. This file has had the care plan reviewed and updated, though there was no clearly documented record of the evaluation. The resident's file does have documented outcome scores using the electronic interRAI assessment. The service has processes in place to use the built in evaluation scores when the service reassesses the resident using the interRAI assessment.</p> <p>The evaluations that have been conducted in eight files reviewed document how the resident is progressing towards meeting goals. When there are changes in the resident's needs, the service uses a short term care plan to capture these changes. The short term care plans identify the need, interventions and evaluation of the</p>

		interventions. If the issue then becomes a long term need, these are then recorded and updated on the long term care plan.
<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>The service has a number of GPs that provide coverage to the residents and each of the residents maintain their own GP if available. The GP or RN arranges for any referral to specialist medical services when it was necessary. The residents' files have appropriate referrals to other health and diagnostic services.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policy which describes safe and appropriate storage and disposal of waste substances is implemented at Metlifecare Somervale to protect staff, residents and visitors from harm as a result of exposure to waste products. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes.</p> <p>Oxygen bottles are securely stored. Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons as required.</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>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 20 December 2016.</p> <p>There is a process in place to identify and manage maintenance both long term and reactive. Electrical safety testing occurs annually and was completed in April 2016 by a registered electrician. Clinical equipment is tested and calibrated by an approved provider at least annually and was also completed in April 2016.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. For example, one area outside the dining room which is used to store walking frames and wheelchairs during meal times has a clearly labelled warning sign. Regular environmental audits sighted identify that the service actively</p>

		<p>works to maintain a safe environment for staff and residents. Day to day maintenance is undertaken as required as observed during the days of audit.</p> <p>Outdoor areas have appropriate seating and shaded areas which are easily accessible for all residents including wheelchair access.</p> <p>Interviews with residents and family/whānau members confirmed the environment is suitable to meet their needs.</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>Hot water temperatures are monitored and documentation sighted shows they are maintained within safe limits for an aged care facility. During interview with the maintenance person and in documentation sighted it identified that if hot water temperatures go above the stated safe limit a plumber is called to rectify the situation. All residents' bedrooms have toilet and hand basin ensuites and one bedroom has a full ensuite. There are adequate numbers of accessible shower/bathrooms which are conveniently located for residents' use. There are separate visitor and staff toilet facilities.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Bedroom doors are wider than normal to allow the safe use of lifting equipment in all rooms. Bedrooms are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings. All bedrooms are single occupancy.</p> <p>Resident and family/whānau members interviewed confirmed they were happy with their bedrooms and confirm that privacy is never an issue.</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>Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. There are two lounge areas, one is a quiet lounge and the larger lounge is used for activities. There is a separate dining area. Some rest home care residents choose to dine in the village dining area. These are usually residents who have transferred from the village and this allows them to maintain social contact with their friends.</p> <p>Residents and family/whānau reported their satisfaction with the environment.</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>	<p>FA</p>	<p>The service has documented procedures in place for cleaning and laundry tasks. Chemicals are securely stored and correctly labelled. Safety data sheets were sighted for the chemicals in use. The laundry is appropriately equipped with defined clean and dirty areas. The equipment in the laundry is checked regularly and an approved provider undertakes monthly quality and titration checks to ensure the products supplied are being used correctly and are working well. This process is clearly documented.</p> <p>Cleaning equipment is securely stored when not in use. The facility looks and smells clean. Cleaning gained a 100% response from the 2015 resident satisfaction survey results sighted.</p> <p>During interview, residents and family/whānau confirmed they are very happy with the laundry and cleaning services provided. Interviews with cleaning and laundry staff confirmed they comply with policies and procedures and they are happy with the products used.</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>	<p>FA</p>	<p>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked annually by an approved provider. (Last undertaken in April 2016). The approved fire evacuation plan sighted and six monthly fire evacuation drills occur six monthly with the last one being undertaken in February 2016. No follow up was required. There have been no changes to the facility footprint.</p> <p>Emergency supplies and equipment include food and water. There is a civil defence and disaster cupboard which and outbreak kit are checked every six months as sighted on the sign off sheet. The service has an emergency suitcase which is checked weekly. Regular staff education occurred throughout the year which included a Tsunami evacuation drill, fire warden training and first aid.</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and two gas BBQs.</p> <p>The security arrangements include staff checking that doors and windows are locked upon dusk. There is a night porter who works seven</p>

		<p>nights a week to cover night duty and as well as responding to any call bells activated at the village. The night porter undertakes regular security checks throughout the night. Staff and residents stated they feel safe at all times.</p> <p>Resident call bells are located in all resident areas. Resident and family/whānau interviews confirmed call bells were answered in an acceptable timeframe. One complaint sighted in the complaints register for February 2016 related to the time it took staff to respond to a call bell. This had been fully investigated and call bell response times were monitored electronically to show the maximum wait time was less than five minutes. This is fully documented.</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>Resident areas all have at least one opening window which provides adequate natural light. The facility is ventilated via the use of opening doors and windows. The building has electric ceiling heating which is thermostatically controlled. Residents confirm during interview that the facility remains at a suitable temperature throughout the year.</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>A RN is the designated infection control coordinator/nurse for this facility and one other of the Metlifecare services in the Bay of Plenty. The infection control nurse has a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meeting, which the senior management present to the Metlifecare organisational management team on a monthly basis for review and benchmarking. The results are also benchmarked externally three monthly. The managers at Somervale are informed of quality, risk and infection control issues as these occur. The infection control programme has been reviewed within the last 12 months, with this review documenting how the service is meeting their infection prevention and control outcomes.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise relatives not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. The staff demonstrated good knowledge and application of infection prevention and control principles.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>Infection control matters are discussed at the staff meetings conducted monthly. There are three monthly meetings with Metlifecare quality and management teams and the other infections control coordinators across the Metlifecare facilities, with this expert committee available for advice when required at any other times. If the infection control coordinator requires additional advice or support regarding infection prevention and control they can also access this through the DHB, GP or diagnostic services.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies and procedures have been developed by Metlifecare and the use of best practice policies, procedures and resources from a specialist infection prevention and control consultancy service. The policies and procedures cover all aspects of infection control management, including the correct use of personal protective clothing/equipment. These policies are appropriate to the services offered by the facility.</p> <p>All staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions according the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator conducts most of the infection control education. There are some visiting specialists who provide infection control education. The infection control coordinator demonstrated current knowledge on infection prevention and control. The infection control coordinator has attended ongoing education on current good practice in infection prevention and control. As required, infection control education can be conducted informally with residents, such as reinforcement of infection control practices with washing hands, blowing nose, cough etiquette and personal hygiene when assisting with toileting.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is monthly collection, collation and analysis of infections. The service uses standardised definitions, applicable to aged care, to identify infections. The type of surveillance undertaken is appropriate to the service. Data is collected on urinary tract infections, influenza, skin infections and respiratory tract infections.</p>

		<p>The infection data reviewed for 2016 records the collation, analysis, graphing and trending of the infection data. The analysis includes comparisons with the previous month, reasons for any increase or decrease and actions, advice and recommendations for reducing infection occurrence. The outcomes are fed back to the staff at the next staff meeting.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. It states that the service aims to minimise the use of restraint and to ensure that if restraint is necessary, to keep the resident safe from harm. The use of enablers are voluntary and the least restrictive option to meet the needs of the resident. Policy contains all necessary documentation related to the use of restraint.</p> <p>The service has managed to gain a restraint free environment and had no restraints or enablers in use at the time of audit. Clinical staff undertake annual restraint minimisation education; last presented in June 2015. Staff are required to complete a written competency related to the safe and correct use of restraint should it be required. During interviews, staff verbalised their understanding and knowledge related to restraint and enabler use.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	<p>Policies and procedures are in place and available to all staff. Not all policies sighted are up to date but there is a process in place to manage this at head office and all updated policies are sent to the service and a process is in place to ensure all staff are aware of any changes.</p>	<p>Not all policies sighted are up to date.</p>	<p>Provide evidence that all policies are current and reviewed within timeframes identified on each policy.</p> <p>180 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and</p>	PA Moderate	<p>The medication records reviewed are dated, signed off and signatures can be verified with the specimen signature list. Photo-identification was observed on each record sighted. Allergies and sensitivity are documented on signing sheets. There is evidence that signing sheets are recorded appropriately and alert stickers are</p>	<p>Six prescribed medications in the 14 medications charts reviewed did not contain the route of administration. In four of the 14 medication charts, the indication for as required (PRN) medication use are not clearly identified.</p>	<p>Ensure the medication prescription on the medication chart has all the required information and that indications for use are recorded for all PRN medications.</p>

guidelines.		available. Most of the medication charts have been generated by the pharmacist from the GP prescription and contain all the required information and level of detail to comply with legislation and aged care guidelines. There are some medication charts that have hand written amendments by the GP, with not all these changes containing the route of administration or what the 'as required' (PRN) medication is to be used for. The service is planning to transition to a cloud based medication management system from July 2016.		90 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The achievement of the use of data analyses to improvement services are rated beyond the expected fully attainment. Areas of deficit have been addressed by the service undertaking special projects such as falls management and the introduction of a falls prevention and management team who document clearly all actions put in place. This information is shared with staff, visiting providers and residents so they are kept fully informed of what is happening. The projects show a documented review process with analysis and reported findings. For example, a January 2016 audit of falls prevention and management gained a 33% compliance. Eight corrective actions were identified and completed and a re-audit of falls prevention and management showed a positive compliance outcome by gaining a 90% rating in April 2016. This project included staff knowledge</p>	<p>The service can demonstrate that data collected is analysed and evaluated. Evaluated results are used to make improvements to services by undertaking required follow up as clearly documented projects. The outcomes are measurable and identify how residents benefit from actions put in place.</p>

		and education, environmental issues, GPs and pharmacy input regarding medication usage (polypharmacy), and dietary reviews. This project resulted in a 50% decrease in falls as identified in data sighted. The positive outcome is also measured from feedback from staff and family/whānau members. (Also refer to comments in standard 1.3.7).	
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>The achievement of the depth to which corrective action planning is addressed at Metlifecare Somervale is rated beyond the expected fully attainment. For example, corrective planning projects include skin integrity, falls prevention, GP visit compliance with documentation and medication administration. The service has established a Quality Improvement and Monitoring team who follow up on all corrective actions and report on the success of the projects put in place. The corrective actions put in place clearly identify the actions needed, who is responsible for oversight of each action and are time-lined for completion. This information is shared at staff and management level. All completed projects have gained positive outcomes, such as a reduction in skin tears from 49 to 28 over a three month period and a 50% reduction in falls. All projects have measurable outcomes in data collected. This has resulted in improvements to residents' safety.</p>	<p>The service has set up a quality improvement team to ensure all corrective action planning is addressed to reflect current best practice and is undertaken within set timelines. Results sighted identify changes made to some aspects of service delivery and staff awareness ensure a safer environment for residents.</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Activities have been the focus of one of the 2016 quality initiatives and include the introduction of scrapbooking, pen pals, sensory profiling and additional activities for residents needing diversion outside planned hours. The project on sensory profiling for residents with cognitive impairment was sampled.</p>	<p>The achievement of the quality improvement projects in activities and diversional therapy programmes are rated beyond the expected full attainment. With these projects there has been a documented review process which includes the analysis and reporting of findings. The projects include documenting actions to make improvements in the programme and in increasing</p>

			staff knowledge of the resident's individual sensory needs. This has resulted in increased staff interaction and engagement of the residents with cognitive impairment in meaningful ways and provides confidence and skill in caring for the residents who have limited or no verbal communication. Positive outcomes have been measured from feedback from management, staff, and family members.
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End of the report.