

# Sprott Care Limited

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## 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:

<b>Legal entity:</b>	Sprott Care Limited
<b>Premises audited:</b>	Sprott House
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 26 April 2016    End date: 27 April 2016
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	92

# 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

Sprott House is a not-for-profit organisation owned by a board of trustees, and operated by a general manager. Rest home, hospital and dementia level of care is provided for up to 97 residents. On the day of the audit, there were 93 residents.

The general manager has been with the service for six years. A clinical and non-clinical management team supports her. The residents and relatives spoke positively about the care and supports provided at Sprott House.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, relatives, general practitioner, management and staff

The service has addressed one of two previous audit findings around dementia care training. Improvements continue to be required around monitoring.

The service has maintained continuous improvement rating around activities.

## 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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There is an open disclosure and interpreter's policy. Management promote open disclosure and have an open door policy. There is a complaints policy supporting practice and an up-to-date register. Staff interviews confirmed an understanding of the complaints process.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Sprott House has embedded a quality and risk management system that supports the provision of clinical care. Key components of the quality management system, link to a number of facility meetings including health and safety/infection control committee meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes.

## 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 low risk.</p>
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A registered nurse completes initial assessments and InterRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the InterRAI outcomes and other assessments and are clearly written and caregivers report that they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process.

Each resident has access to an individual and group activities programme. There are activities planned to cover the 24-hour period for residents in the dementia care unit

Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. All staff administering medications have annual competencies and education.

Meals are prepared on site by a contracted agency under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for and nutritious snacks are available over the 24-hour period. Residents interviewed were complimentary about the food service.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has a current building 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.
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There are policies and procedures for the use restraint or enablers that align with the restraint minimisation safe practice standards. The policy includes the definition of the use of enablers. There were 12 residents using restraints and 6 residents using enablers. The unit manager/occupational therapist is the restraint coordinator. Staff receive training around restraint/enabler use including the management of behaviours that challenge.

## 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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinators (quality manager and clinical services manager/registered nurse) are responsible for collating infection events and providing a monthly report to management and staff. Infection control policies and guidelines include definitions for surveillance. The infection control coordinators use the information obtained through surveillance to determine infection control activities and education needs within the facility.

## 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	14	0	1	0	0	0
<b>Criteria</b>	1	37	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service. The general manager maintains a record of all complaints, both verbal and written, by using a complaints' register. There have been seven complaints made in 2015 and two to date for 2016. All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced timely acknowledgement of the complaint by letter, investigation notes and resolution of the complaint to the satisfaction of the complainant. Advocacy has been offered as part of the complaints process. Residents and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments were evident in facility meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Management promotes an open door policy. Relatives interviewed (two hospital and two dementia care) were aware of the open door policy and confirm the staff and management are approachable and available. Residents/relatives have the opportunity to feedback on service delivery through annual surveys. Results and corrective actions/areas for improvement are discussed at resident meetings and included in the seasonal newsletters for residents/relatives and staff. There are resident meetings held in each unit that are open to families to attend. Accident/incident forms reviewed evidenced relatives had been notified of incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to resident's health status.</p>

communication.		Residents and family are informed prior to entry; of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required.
<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>Sprott House provides rest home, hospital and dementia level care for up to 97 residents. Seventy three beds are dual purpose rest home/hospital level. The dementia care unit has 24 beds. Renovations have not yet begun on the additional dementia care room approved by HealthCERT October 2015 (link 1.4.2)</p> <p>On the day of audit, there were 33 rest home residents, 37 hospital residents and 22 dementia care residents. All residents were under the ARCC. Respite service are provided as required. There were no residents under 65 years of age.</p> <p>Sprott House is a not-for-profit organisation governed by a board of trustees. The Trustees/directors employ a general manager (also a director), who provides management and clinical information to the board. The general manager attends board meetings and is responsible for the operation of the residential service and the 13 villas on-site.</p> <p>The general manager has been with the service six years and is supported by a clinical services manager/registered nurse, finance and administration manager, support services manager (non-clinical) and a quality/education manager.</p> <p>There is a strategic plan, a business plan, and a risk management plan covering 2012 to 2017, which identifies the philosophy of care, mission statement and business objectives/goals and the values of the trust and the risks identified by the management team and the board. The board of directors, general manager and management team review the strategic and business plans as required and the risk management plan annually. Quality goals for 2016 include improved information exchange through updating the facility website, introduction of an electronic medication system and the addition of another dementia bed.</p> <p>The village manager has maintained at least eight hours annually of professional development related to managing a rest home/hospital/dementia care service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and</p>	FA	<p>The service has a quality risk management plan in place that is reviewed annually. A range of policies and procedures support service delivery that meets the required standards and legislation. The use of InterRAI assessments are linked into clinical management processes. Facility meetings include management, clinical, unit managers, health and safety and quality meetings.</p> <p>Meeting minutes sighted evidence there is discussion around quality data including complaints, compliments, health and safety, accident/incidents, infection control, internal audit and survey results. Staff interviewed (seven caregivers, three registered nurses and three unit managers) state they are well informed and have ready</p>

<p>risk management system that reflects continuous quality improvement principles.</p>		<p>access to meeting minutes.</p> <p>Internal audits are completed as scheduled. Corrective actions are raised for any areas of non-compliance and are re-audited in three weeks and signed off when completed. Resident/relative satisfaction surveys are completed annually. Results viewed had been collated and fed back to the participants and included identified areas for improvement.</p> <p>The quality manager/health and safety officer (non-clinical) shares the health and safety role with the clinical services manager/registered nurse. The health and safety officer has completed external health and safety training and attends the district health board risk management group meetings. Each wing has two health and safety representatives. All representatives have attended health and safety training. The health and safety committee meets three monthly. The meeting minutes evidence trends and analysis of accidents/incidents. The hazard register is current. The health and safety policies have been reviewed to reflect current legislation.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accident/incident policy, which is part of the risk management and health and safety framework. The service collects incident and accident data and reports monthly to the health and safety officer, clinical meetings and the three monthly health and safety committee. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted.</p> <p>Sixteen accident/incident forms (seven rest home, six hospital and three dementia-care) were reviewed from February, March and April 2016. All incident forms identified timely RN assessment of the resident and corrective actions to minimise resident risk. Not all neurological observations had been completed for unwitnessed falls and any known head injury (link 1.3.6.1). Next of kin had been notified for all incidents/accidents as per written instructions for notification of accident/incidents. The caregivers interviewed could discuss the incident reporting process. The clinical services manager investigates reviews, and implements corrective actions as required.</p> <p>The general manager interviewed could describe situations that would require reporting to relevant authorities. There have been two section 31 reports to HealthCERT that have been closed-out. One sentinel event has been reported to the Ministry of Health and Worksafe NZ. Internal investigations were completed for the three sentinel events.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. The register of nursing practising certificates and allied health professionals is current. Seven staff files were reviewed (three RNs, two caregivers, one laundry and one cleaner). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed are able to describe the orientation process and</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>believed new staff were adequately orientated to the service. Staff complete competencies relevant to their roles.</p> <p>Caregivers are supported to complete careerforce aged care qualifications. The clinical services manager is a careerforce assessor. Nursing staff are supported to attend external education. Seven RNs (including the clinical services manager) have completed their interRAI training.</p> <p>The staff training plan has been changed to monthly full study days that cover the mandatory requirements. Other training provided on-site includes moving and handling (physiotherapist) and medication (pharmacist). All nursing staff, caregiver team leaders and activities personnel have current first aid certificates. All 24 caregivers who work in the dementia care unit have completed the dementia unit standards. The previous finding around dementia unit standards has been addressed.</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>The human resources policy determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager and the clinical services manager/RN are on duty during the day Monday to Friday. The clinical services manager provides the on-call requirement for clinical concerns and the general manager facility concerns. There are two qualified nurses on duty 24 hours. One RN provides clinical support to the dementia unit as required. The unit manager for the dementia care unit is a qualified occupational therapist. Residents and relatives state there were adequate staff on duty at all times. Staff state they feel supported by the clinical services manager and general manager who respond quickly to after hour clinical or facility concerns.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed on an annual basis, for competency. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. The registered nurses and care staff interviewed were able to describe their role concerning medicine administration. There were no self-medicating residents on the day of audit.</p> <p>All twelve medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed the medication chart three monthly.</p> <p>Medications are delivered to the site by the pharmacy. The fortnightly robotic rolls are checked and signed-in by a registered nurse.</p> <p>Medication fridge temperatures are monitored and temperatures are within acceptable range.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Sprott House are prepared and cooked on site by a contracted service, and supervised by a qualified chef. There is a four weekly summer/winter menu, which has been reviewed by a dietitian. Meals are delivered to each unit's dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Family surveys and interviews with residents allow the opportunity for resident feedback on the meals and food services generally. Residents/family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked and prior to serving food temperatures are recorded on each meal. The dishwasher is checked regularly by the chemical supplier.</p> <p>There is evidence that additional nutritious snacks are available over 24 hours in all areas.</p> <p>All food services staff undertake training in food safety and hygiene, and chemical safety.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition alters, the registered nurse or clinical manager initiates a review and if required, GP or specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health. The registered nurse (RN) and caregivers follow the care plan and report progress against the care plan each shift at handover (witnessed). Care plan interventions record residents' needs. Interviews with the unit managers and the RNs demonstrated an understanding of the individualised needs of residents.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound assessment, monitoring and wound-management plans are in place for all wounds. On the day of audit, there were nine skin tears, two chronic wounds and two residents with donor and graft site wounds. There was one stage-one pressure injury. There is evidence of GP, dietitian and specialist involvement in wounds/pressure injury management.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>There are monitoring forms in place such as blood pressure, weight, pain and neurological observations. Implementation and completion of neurological observations was not fully evident. The previous finding remains open.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part</p>	<p>CI</p>	<p>The service has a recreation manager (RM) who has qualifications in art and psychotherapy and is working towards a diversional therapy qualification. The RM oversees two activity assistants and a volunteer. The activity assistants are also undertaking diversional therapy training. An activity assessment is completed on</p>

<p>of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>admission in consultation with the resident/family (as appropriate), and again following three weeks, three monthly then six monthly. Activity plans sighted in all six files cover the 24-hour period and were reviewed six monthly at the same time as the care plans. The service has maintained a continuous improvement around provision of activities and recreation.</p> <p>A wide range of activities is offered and reflects resident's needs, and participation is voluntary. One-on-one activities occur for residents who are unable or choose not to be involved in group activities. Activity participation sheets were maintained along with weekly progress notes. In the dementia unit, staff were observed at various times throughout the day diverting residents from behaviours. The individual activities observed were appropriate for people with dementia. There were resources available for care staff to use for one-on-one time with the resident over the 24-hour period. Residents in the rest home and hospital stated they were satisfied with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans were reviewed at least six monthly and have been updated as changes were noted in care requirements. Care plan evaluations were comprehensive, relate to each aspect of the care plan and record the degree of achievement of goals and interventions. Short-term care plans are utilised for residents with short-term needs and any changes to the long-term care plan have been dated and signed.</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>	<p>FA</p>	<p>The facility displays a current building warrant of fitness, which expires on 18 July 2016.</p> <p>Environmental improvements include refurbishment of rooms as they become vacant, improved lighting in bedrooms, new bath installed that can be used for hoist transfers, and three new chair scales.</p> <p>Architectural plans are being developed for the conversion of a storeroom to an additional dementia care room, however renovation has not yet commenced and therefore was not reviewed at this audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator/quality manager shares the role with the clinical services manager. Both have attended external education. Infection rates obtained through surveillance are used to determine infection control activities and education needs in the facility. Infection rates, types, and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the management and staff meetings. Trends are identified and preventative measures put in place.</p>

<p>methods that have been specified in the infection control programme.</p>		<p>Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP who advises and provides feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There was one outbreak in June 2015 that was contained and managed appropriately. Relevant authorities had been notified and commended the service on their outbreak management practices.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The unit manager/occupational therapist for the dementia unit is the restraint coordinator. Staff receive annual training on restraint/enabler use. On the day of the audit, there were six residents with enablers (two rest home and four hospital) and 12 hospital residents with restraint (all bedrails). The restraint oversight committee reviews all enabler and restraint use at least three monthly. Enablers are voluntary.</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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Incident/accident forms are completed for all witnessed and unwitnessed falls. The RN on duty completes a clinical assessment of the resident immediately post fall. Neurological observations reviewed had not always been commenced for unwitnessed falls and/or had not been continued for the required period of time as per best practice.</p>	<p>Six neurological observations commenced for witnessed falls had been completed but over variable time periods. There were no neurological observations for two residents who had seven unwitnessed falls.</p>	<p>Ensure neurological observations are completed for a specified timeframe consistent with best practice for all witnessed falls where the resident has hit their head. Ensure neurological observations are commenced and completed for all unwitnessed falls if there is suspicion that the resident may have suffered trauma to the head as per facility policy.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</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>The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families.</p>	<p>Due to feedback received from residents and families in February 2016, the service has increased the provision of musical entertainment from once a week to twice a week. A music therapist has also been contracted for weekly sessions.</p> <p>There is an ongoing project to identify residents at risk of isolation with targeted interventions implemented to reduce the risk. There is an activity person assigned to each unit with separate activity programmes that meet the recreational needs and preferences of each group of residents. Wi-Fi has been installed for resident and family use to enhance communication between family and friends. A community project was undertaken to landscape the dementia unit outdoor courtyard with raised garden beds, sensory gardens, seating and shade sails.</p> <p>Achievements to date include the coordination of a volunteer group who provide one-on-one time with residents at risk of isolation, especially in the weekends. On the day of audit, the courtyard was observed being used by residents and families. Dementia care relatives interviewed commented on the environmental improvements. The resident/relative satisfaction survey showed an increase in satisfaction around the activity programme.</p>

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End of the report.