

Briargate Healthcare Limited - Briargate Dementia Care Unit

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Briargate Healthcare Limited

Premises audited: Briargate Dementia Care Unit

Services audited: Dementia care

Dates of audit: Start date: 24 August 2016 End date: 25 August 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 39

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Briargate Dementia Care Unit (Briargate) is one of three facilities owned and operated privately by the same owners. Briargate provides secure care for up to 40 residents with dementia.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included the review of documentation, observations and interviews. The onsite documentation review included a selected number of residents' files. Interviews were conducted with the owner/directors, facility manager, clinical and non-clinical staff, residents and family/whanau. Residents were not able to respond to all questions asked owing to their short term memory loss. Neither the general practitioner nor nurse practitioner were available for interview on the days of audit. The audit report is an evaluation of the combined evidence on how the service meets each of the standards.

There were no areas identified for improvement at this audit. Activities are a strength of the service and have gained a higher than usual (continuous improvement) rating.

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.

Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of health and Disability Services Consumers' Rights (the Code). Families and residents interviewed expressed satisfaction with the caring manner and respect that staff show towards each resident.

There were two residents whom identify as Maori residing at the service at the time of audit. There are no known barriers to residents accessing the service. Services are planned to respect the care required, culture, values and beliefs of all the residents as individuals and as a collective.

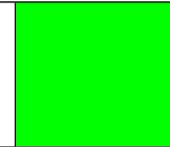
Written consents are obtained from the residents' families/whanau, enduring power of attorney (EPOA) or appointed guardians, when necessary.

Residents are encouraged and supported to maintain strong community and family links.

The organisation respects and supports the right of the resident to make a complaint. The service has a complaints register and the information is recorded to meet the requirements of the Code. There were 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.



Standards applicable to this service fully attained.

The owner/directors are actively involved in the management of Briargate and have responsibility for quality and risk management processes. The facility manager, who is a registered nurse, oversees and is responsible for all clinical care. They are suitably experienced and qualified for the role and supported by two registered nurses.

Facility structures and processes are monitored at organisational level. Service performance is aligned with the organisation's philosophy and goals identified in the quality and risk plan.

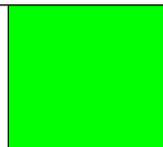
The service has a documented quality and risk management system that supports the provision of safe clinical care and support. Policies are reviewed and maintained by an off-site provider and maintained to meet all legislative and standard requirements. The policies and procedures are personalised for Briargate and documented to guide staff on all aspects of service delivery.

All aspects of service are reviewed by the quality committee quarterly and a major annual review is undertaken at senior management level. Both onsite and off-site trending and benchmarking occurs. The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events. Family/whanau confirmed they are kept fully informed at all times.

Systems for human resources management are established and implemented. The education programme for staff is available and planned for the year. Training to meet contractual requirements for clinical staff who work in the dementia unit is provided.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

Pre-admission information clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

Residents are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops, with the resident, family and existing community supports and health care professionals, a care plan specific to the resident. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan, as needed. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All residents have 'interRAI' assessments completed and individualised care plans related to this programme.

Residents are reviewed by the nurse practitioner (NP) on admission and assessed thereafter either monthly or three monthly by the NP depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

Activity coordinators provide planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes accommodated. The service has a four week rotating menu which is approved by a registered dietitian. Resident's nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

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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All building and plant complies with legislation, with a current building warrant of fitness displayed. Ongoing maintenance and compliance is well documented with timelines being met. Routine safety checks and internal audits are performed by the facility manager and one of the owner/directors who oversees all maintenance.

All bedrooms are single occupancy and have ensuite toilet and hand basin facilities. There are adequate shower and bathing facilities located throughout the facility that provide privacy.

The environment is appropriate for secure dementia care services, minimises risk of harm and promotes safe mobility. All areas ensure physical privacy is maintained and have adequate space and amenities to facilitate independence. There are processes in place to protect residents, visitors, and staff from exposure to waste and infectious or hazardous substances.

Laundry and cleaning services meet all standard requirements. Chemicals are securely stored.

The facility had an appropriate call system installed. There is easy access to secure external gardens. Emergency preparedness was evident with adequate resources being available in the event of an emergency. Staff are trained appropriately in all aspects of health and safety in the work place.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has a commitment to the non-use of restraint or enablers. This has been maintained since the previous audit. Clear definitions of restraint and enablers are shown in the policy reviewed and staff reported a good knowledge and understanding of what needs to occur should restraint ever been required. The staff are well versed in the management of challenging behaviour.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff, and when appropriate, the residents and their families. There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. There has been an infection outbreak since the previous audit. The outbreak was managed and met all legislative and standard requirements. The infection surveillance results are reported and discussed at staff and residents' meetings.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	0	0	0	0	0
Criteria	1	92	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The consumer rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with a copy of the Code on admission and a copy is displayed on the main corridor wall in full view for residents, staff and visitors and evidenced as discussed again in family meetings.</p> <p>On commencement of employment all staff receive induction orientation training regarding residents’ rights and their implementation. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information</p>	FA	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents’ files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA). Advance directives are signed by the resident if competent. Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received</p>

<p>they need to make informed choices and give informed consent.</p>		<p>and families/whanau were actively encouraged to be involved in their relative's care and decision making.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>All residents receiving care within the facility have appropriate access to independent advice and support, including access to a cultural and spiritual advocate whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. The facility has access to an advocate through the district health board.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident's progress notes and care planning, such as daily van trips and the attending of different community churches and special events held.</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>The complaints register sighted identified the required procedures are being followed. The complaints register records the complaints, dates, actions taken and date of resolution. Complaints are actively managed in a timely manner and in accordance with the complaints policy, and any other statutory requirements relevant to the specific situation.</p> <p>Complaints management information is included in resident information packs given on admission, and as confirmed by the facility manager, the process was discussed with family/whanau and residents as part of the admission process. This is confirmed in family/whanau interviews.</p> <p>Complaints forms are accessible to staff, residents and family/whanau as required. Advocacy service contact numbers are included in information given. This was verified in one complaint of a minor nature made being presented by the local Health and Disability advocate on behalf of the resident. The service investigated the complaint and a resolution was gained with no follow up required. There are no outstanding complaints at the time of audit.</p> <p>Staff interviewed confirmed their understanding of the complaints process.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is evidenced in the admissions agreement.</p> <p>The family/whanau that were interviewed reported that the Code was explained to them on admission. The Code of Rights and process was also regularly discussed at family/resident meetings. Family/whanau expressed that they were happy with the care at the facility and provided by the staff.</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>	FA	<p>The residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The families/whanau interviewed reported that the staff are meeting the needs of their relatives.</p> <p>The families/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.</p> <p>No concerns in relation to residents' abuse or neglect were mentioned. The family members reported that staff know their relatives well. This was also evidenced at the time of audit with observed interactions.</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 registered nurse and nurse manager reported that there are no barriers to Maori accessing the service. At the time of the audit there were two Maori residents whom affiliated with their Maori culture. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	FA	<p>The spiritual, religious and cultural standard operating procedure documents that the admission process includes assessing specific cultural, religious and spiritual beliefs, which includes any cultural nutritional requirements. Staff liaise with family/whanau to ensure cultural or religious visits continue as appropriate. Education on cultural sensitivity and spirituality has been completed. Families and relatives interviewed</p>

Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		were happy with the care provided by those staff who also identify with a different culture.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Evidence-based practice was observed and evidenced in interviews with the facility manager, registered nurses, care givers and in care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' nurse practitioner, links with the mental health services, hospice, the geriatrician and different DHB nurse specialists and consultants. Care guidelines are utilised as appropriate.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit two residents did not speak English and eight residents had identified English as their second language. The majority of the families interpreted when required with staff managing well with hand gestures, word/picture cards and body language. The family/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at handover.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of	FA	On the day of audit there were 39 dementia care residents. The strategic plan for 2016 contains the organisation's mission, values and goals. There are long term and short term goals within the plan. The plan is reviewed on an annual basis as confirmed in documentation sighted.

<p>consumers.</p>		<p>The facility manager is a registered nurse (RN) with over 20 years' experience in aged care with 10 years of this being in management positions. They have worked in dementia care for over four years. The facility manager's job description describes their responsibilities, accountabilities and authorities. The facility manager has attended over eight hours of education in the past 12 months related to leadership and management in the aged care sector.</p> <p>The facility manager is supported by two RNs and the two owner/directors. One owner/director is on site most days with the responsibility for finance and the other owner/director undertakes and oversees all maintenance issues. One owner/director attends all senior staff meetings and the quarterly quality review meetings so that there is awareness of all current issues.</p> <p>The family/whanau and residents confirmed they were satisfied with the services provided and that resident needs were met.</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>If the facility manager is away the most senior RN undertakes this role. During interview the RN stated they are aware of what is required and that they can seek help and assistance from other senior clinical staff from one of the organisation's sister facilities if required. The owner/directors are always available via telephone if they are not on site. The facility manager reports the RN will receive ongoing support and education related to the management side of their role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a quality and risk plan which details the risks, current controls and ongoing actions undertaken to ensure resident needs are being met and to provide a safe and appropriate environment. The quality and risk systems are monitored quarterly with annual reports being documented and reported on to the owner/directors. One owner/director attends the quarterly review meetings.</p> <p>The quality goals identified cover all aspects of care and service delivery. The outcomes of the internal auditing and quality management systems are discussed at the monthly staff meetings. Staff confirmed they understood and implement the quality and risk management systems. One owner/director attends the monthly senior staff meetings, held on the same day as staff meetings, as confirmed in meeting minutes sighted.</p> <p>The policies are developed by an external consultant. All policies and procedures sighted were up to date, reflected current good practice and met legislative requirements. As part of the quality management system, the organisation has a process in place to ensure all documents are reviewed at least two yearly.</p>

		<p>The document control system ensures that obsolete documents were removed from use. The review of policies or any updates are distributed to staff to read so they are aware of any required changes.</p> <p>The organisations risk management plan identified risks and showed the strategies in place to manage risks. All potential and actual risks are reported at senior staff level and reviewed at the quarterly quality meetings. Clinical risks are discussed monthly at staff meetings as confirmed during staff interviews. There was an up to date hazard register and the process for reporting hazards was understood by staff.</p> <p>Quality data collection and analysis is maintained by the service and evaluation of results shared with staff and management. Quality improvements are put in place where indicated. When the internal audit or quality data indicates any shortfalls, corrective actions are put in place. The internal audit form records the identified issue, actions needed, who is to implement the actions and the review of when the actions have been implemented. Staff confirmed that all follow up actions were discussed during handover and at staff meetings. For example, following a recent infection outbreak the follow up actions were documented and implemented as per the public health service visitor's advice. Quality data is collected, trended, reviewed and evaluated for all key components of service (complaints, incidents and accidents, health and safety, hazards, restraint and infection control). The graphs and analysis of the quality data identifies any trends.</p> <p>Infection control, falls, challenging behaviour, hospital admissions and incident accident data is benchmarked against other like services and data sighted shows that Briargate remains in the lower sector of percentages shown. Medication management data is also benchmarked electronically with monthly printouts sighted. Follow up actions had been fully implemented and resolved at the time of audit.</p> <p>Family/whanau report that they are kept informed of what is happening at the facility during quarterly open forum meetings and via email or telephone.</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>The facility manager understands their obligations for reporting serious harm and essential notifications. Two notifications were sighted, one related to an infection outbreak and one serious harm following a fall. The facility manager reported they understood the need to use section 31 reporting forms.</p> <p>Staff reported that they complete incident and accident forms for adverse events and always report this to senior staff. There is a monthly analysis of the incident and accident reports. The analysis of the incidents and accidents are used to implement improvements as indicated. The analysis includes the numbers of falls and the times that falls are occurring. For residents who have had increased falls, strategies are implemented to reduce the number of falls.</p> <p>The annual quality review undertaken February 2016 identified that some staff required a more in-depth knowledge of challenging behaviour management. Additional education was presented in March and June 2016 to ensure all staff gained a greater knowledge and understanding of challenging behaviour management. This was confirmed in documentation sighted and during staff interviews. Family/whanau</p>

		interviewed were able to reported examples of staff managing challenging behaviour situations very well.
<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>Professional qualifications and annual practising certificates (APCs) are validated on employment and annually. The service maintains a folder of current APCs which was sighted for all staff and contractors who require them.</p> <p>The staff files evidence that good employment processes are implemented, such as recruitment, interview, police vetting and reference checking. Annual performance reviews are up to date in the staff files sampled.</p> <p>The service requires all staff to complete an orientation and induction programme which is clearly documented. There is an initial two-day orientation that all new staff complete, then role specific orientation for the different roles within the services. The initial general orientation covers a wide variety of aspects including emergency management, handling concerns and complaints, cultural best practice, infection control, waste management, keeping the environment safe, confidentiality, privacy, informed consent, incidents/accident reporting, managing challenging behaviours and the non-restraint minimisation policy. Staff reported that the orientation and induction gave them a good understanding of their role and responsibilities.</p> <p>The in-service education programme covers the essential components of service delivery for dementia level of care. The service also accesses ongoing education support from the DHB aged residential care programme, gerontology nurse specialists and community mental health services. The care staff either hold or are working towards educational qualifications related to national unit standards for dementia care to ensure contractual requirements are met. Attendance records are kept for the education that staff have attended, as sighted in each of the staff member's personnel files.</p> <p>The facility manager and both RNs have completed their interRAI training and maintain their competencies. Certificates were sighted.</p> <p>Staff reported that they are supported and encouraged with maintaining their knowledge and skills and that any areas of additional training they require are put in place.</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</p>	FA	<p>There is clearly documented policy on staffing levels and skill mix to meet the needs of residents requiring secure dementia level of care. There is at least one RN on duty each morning shift.</p> <p>Four caregivers work eight hours and one works six hours each morning, four caregivers work eight hour afternoon shifts with a five and half hour short shift. Two caregivers work eight hour night shifts.</p> <p>There are dedicated activities, cleaning and laundry staff seven days a week. There is at least one staff member on duty each shift who has current first aid qualifications and who holds completed specific</p>

providers.		<p>dementia care qualification.</p> <p>Staff confirmed they have adequate time to do their required work and all staff assist in implementing meaningful activities for the residents throughout their shifts. This was observed both days of audit. Refer comments in standard 1.3.7.</p> <p>Family/whanau and resident interviews confirmed staff remain visible and available at all times.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents' information sighted. Clinical notes were current and integrated with medical and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the NP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP/NP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's record reviewed. No personal or private resident information was observed to be on public display during the days of audit. Archived records were being safely held on site for seven years.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The resident admission agreement is based on the Aged Care Association agreement. The residents' records reviewed have signed admission agreements by the resident/family or EPOA.</p> <p>Vacancies are updated daily through Eldernet. Staff contact the nurse manager if enquiries are made by potential perspective residents and/or their family members and if outside working hours staff are guided by facility guidelines.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service uses the DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information.</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>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit no residents were self-administering medications.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley individually in the treatment rooms which is locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted. Medications that require refrigeration are stored in a separate fridge with recorded temperatures documented.</p> <p>The facility has implemented an electronic medication charting and management system. The 14 medicine charts sighted have been reviewed by the NP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (PRN) medications identified had the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident.</p> <p>There are documented competencies sighted for designated care staff responsible for medicine management. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management.</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>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. Kitchen staff interviewed had a very good understanding of food safety management and have completed ongoing updated food safety training.</p> <p>There is a four week rotating menu that has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the NP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>The kitchen also offers residents a variety of cereals for breakfast, a main option for lunch including a desert and a lighter menu option for dinner also supporting individual residents with different cultural food needs. All main meals are supported by morning and afternoon tea which includes home baking.</p>

		All meals are cooked and served directly from the kitchen and served in the adjacent dining room. Residents have the option of trays in their rooms, however all residents are encouraged to have their meals in the dining rooms to encourage appetites and socialisation.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The nurse manager and registered nurse interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The service has implemented the electronic interRAI assessment and specific assessment tools for all residents. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and includes falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life, self-medication and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The residents' files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure injury risk assessments.</p> <p>The family/whānau interviewed reported their relative receives 'above and beyond the care required' to meet their relative's needs.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The seven residents' files reviewed have electronic care plans that address the resident's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the residents' files. Also evidenced is the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The caregivers interviewed demonstrated knowledge about the individual residents they care for.</p>

		<p>The residents' files reviewed included diversional therapy care plans identifying the resident's individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files showed input from the nurse manager, registered nurse, care and activity staff and medical and allied health services. The registered nurse and caregivers interviewed reported they receive adequate information to assist with the resident's continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the days of the audit, the registered nurse and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals. The registered nurse and caregivers interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme uses a framework to empower the residents both young and older to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinator adapts activities to meet the needs and preference of choices/cultural preferences of the aged care residents.</p> <p>The facility has one diversional therapist who works Monday – Friday, a total of 40 hours per week and attends regular education/support group sessions related to his role. This role is supported by a trainee diversional therapist who works three days a week, a total of 16 hours per week. The weekly activities plan/calendar sighted is developed based on the resident's individual needs and interests and can be easily adapted and changed depending on the resident's physical ability, interest and reaction at the time. The activities staff advertises the upcoming activities on the calendar by providing this to residents on the notice</p>

		<p>boards through the facility. Regular activities include daily newspaper reading and exercises, church services, regular visiting entertainment and includes daily weekly van trips. All public holidays and special events are celebrated. For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff promote social interaction by inviting and encouraging all residents to join in activities together in the main lounge.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file three monthly.</p> <p>The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.</p> <p>All residents and families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their NP and family/whanau. Short term care plans are sighted for wound care, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents' progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p>	<p>FA</p>	<p>There is one nurse practitioner who visits the residents at the facility which also includes an on call component. The RN in discussion with the NP will arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The NP was unavailable at the time of audit but it is reported</p>

<p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>by the RN that appropriate referrals to other health and disability services are well managed from the facility.</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>	<p>FA</p>	<p>The service undertakes appropriate storage and disposal of waste, infectious and/or hazardous substances to comply with current legislation and to ensure visitors and residents are protected from harm. The facility actively recycles plastics and cardboard.</p> <p>Personal protective equipment/clothing (PPE) sighted includes disposable gloves and aprons, goggles and masks. Staff confirm they can access PPE at any time and they can verbalise appropriate use. Staff were observed wearing disposal gloves and aprons as required. Sanitising hand gel is provided at the entrance to the facility and visitors were sighted using this pre and post entry.</p> <p>Approved yellow sharp bins sighted are used for the safe disposal of sharps.</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>All processes are undertaken as required to maintain the service building warrant of fitness. This is confirmed in documentation sighted. The current warrant of fitness expires on 23 January 2017. An exterior and interior maintenance schedule is sighted for 2016. Electrical testing occurred on 09 May 2016. Biomedical and medical equipment were checked by an approved provider in August 2016. Regular controls checks were also sighted for fridges, chiller, washing machines, dryer, heat pumps and the dishwasher.</p> <p>Planned monthly maintenance is undertaken and there is a process for reactive maintenance. Staff and family/whanau confirm any maintenance issued raised are dealt with promptly.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, the correct use of mobility aids and walking areas not being cluttered. Corridors have safety handrails to assist residents to mobilise safely. Residents who have mobility difficulties are assessed by a physiotherapist and appropriate walking aids are obtained as required.</p> <p>Residents have access to secure outdoor areas with seating and appropriate shaded areas. On both days of audit, residents were observed going outdoors as they wished.</p> <p>Interviews residents and family/whanau confirm 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>All bedrooms have toilet and hand basin ensuites. Shower areas are centrally located in each wing. Hot water temperature recording sighted show that they remain within safe limits and remain under 45oC. There are separate staff and visitor 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 single occupancy. As observed, and confirmed by family/whanau, bedroom areas are personalised to meet residents' wants and needs and are large enough to allow residents with or without mobility aids to move around safely.</p> <p>Residents who choose to keep their bedroom doors locked when they are not in their bedrooms are able to do so and there is a master key available to staff to allow cleaning and entry to rooms when required. The doors cannot be locked from the inside.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The physical environment provides safe, age appropriate and accessible areas to meet resident's needs. There are two lounge areas and one dining area. They are all separate rooms. All areas are appropriately furnished. Both lounge areas are used for activities as observed on the days of audit. There is a conservatory off one lounge which is used mostly by family/whanau members when they visit their relatives. The door can be closed to allow privacy.</p> <p>The family/whanau members and residents interviewed confirm their satisfaction with the facilities provided.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services</p>	FA	<p>Cleaning and laundry processes are undertaken as described in policy and according to the job description sighted. This covers required daily tasks and the laundry and cleaning staff interviews confirm they have the appropriate equipment and time to complete all tasks. Staff verbalise their understanding of isolation techniques and knowledge of documented laundry and cleaning process related to outbreak management.</p> <p>Chemicals are premixed and on automatic feed as appropriate. They are closely monitored by the supplier</p>

<p>appropriate to the setting in which the service is being provided.</p>		<p>to ensure they products are effective. This is confirmed by documentation sighted and by the laundry staff member during interview. Laundry and cleaning staff have completed safe chemical handling education in the past 12 months. All chemicals sighted are appropriately labelled.</p> <p>The laundry has a clean/dirty flow, with adequate equipment for the size of the facility. Cleaning trolleys are securely stored when not in use.</p> <p>Interviews family/whanau confirm they are satisfied with laundry and cleaning services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The approved emergency evacuation plan signed off by the New Zealand Fire Service is dated 27 February 2012. There have been no changes to the facility foot print since this time. Six monthly trial fire evacuations are conducted. This was last undertaken in May 2016 with no follow up required. Fire equipment annual checks occurred in January 2016.</p> <p>Staff education related to emergency management occurred in February 2016 this includes a quiz which was completed by all staff. All clinical staff hold current first aid certificates.</p> <p>Civil defence and emergency supplies, including food and water, are checked regularly. There are gas cooking facilities available. First aid boxes are kept in the nurses' clinic and in the kitchen.</p> <p>Call bells are located in all resident areas. When activated there is an audible noise and a LED ceiling display to show where the bell has been activated from. Call bells are checked monthly.</p> <p>Staff are required to ensure doors and windows are securely closed at night. Staff report during interview they feel secure at all times.</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>	<p>FA</p>	<p>All resident areas have at least one opening window to allow natural light and ventilation. Heating is electric with a wall mounted, thermostatically controlled heater in all resident bedrooms. There are electric heat pumps in both lounge areas.</p> <p>The facility was warm on the days of audit. No negative comments were received during interview related to the temperature of the facility.</p>
<p>Standard 3.1: Infection control management</p>	<p>FA</p>	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p>

<p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>The registered nurse is the infection control coordinator and is responsible for following the programme as defined in the infection control manual. Infections are monitored by using standardised definitions to identify infections, surveillance, observing changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meeting. If there is an infectious outbreak this is reported to staff, management and where required to the DHB and public health departments.</p> <p>The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one to one, at shift handover and in resident's documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required.</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>	FA	<p>The registered nurse has the role of infection prevention and control coordinator. Infection control issues are discussed at staff and resident meetings. The facility has the support of a clinical infection control specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources including the laboratory diagnostic services and NP. The infection control coordinator regularly attends infection control education. The registered nurse and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect</p>	FA	<p>An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas including managing sharps, managing multi-drug resistant organisms, exposure of blood and body fluids, personal protective equipment, single use items, outbreak management, cleaning, disinfecting and sterilisation, waste management, construction and renovations. Staff were observed demonstrating safe and appropriate</p>

<p>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>infection prevention and control practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The registered nurse and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing technique of staff is reviewed regularly by the registered nurse. Infection control in-service education sessions are held and resident education is provided, as and when appropriate.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report. The service monitors skin and soft tissue wounds, pressure injuries, urinary tract infections, bronchitis, pneumonia, colds, flu, oral, eyes, ear, gastroenteritis infections, scabies, methicillin-resistant staphylococcus aureus (MRSA), extended spectrum beta-lactamases (ESBL), vancomycin-resistant enterococcus (VRE), and clostridium difficile. Antibiotic use is also monitored. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff and where appropriate family meetings. An external contractor benchmarks surveillance data with other facilities.</p> <p>The Public Health office was notified on the 28 July 2016 regarding a gastroenteritis outbreak. Twenty (20) residents and 11 staff were affected. A plan was developed that included a public health service person visit on site, isolation of residents/staff, and health warning signs/communication were put in place. Cleaning, laundry and personal hygiene were emphasized. The facility was reopened on the 7 August 2016. A corrective action plan was sighted meeting all legislation and standard requirements.</p>
<p>Standard 2.1.1: Restraint</p>	<p>FA</p>	<p>The service has a non-restraint policy. No restraint has been used since the previous audit as confirmed in staff meeting minutes and the quarterly quality review which includes restraint. Policy clearly identified that</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>enabler use is voluntary and the least restrictive option to maintain the resident's independence and safety. All required assessment, reporting and review processes are contained in policy in the event of restraint use.</p> <p>The facility manager (RN) is the delegated restraint coordinator with relevant authorities and responsibilities shown in the job description. The restraint coordinator was knowledgeable about the correct restraint process required should restraint be used. Staff demonstrated good knowledge regarding restraint. They verbalised their understanding of de-escalation techniques when managing challenging behaviour so that no restraint is required. All staff were trained/educated regarding the restraint policy and procedures as well as managing challenging behaviours.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</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 activity programme continues to be reviewed and improved upon with review on a monthly basis. As a result new initiatives and activities are introduced regularly that are of specific interest and culture value to residents with support of family members. Evaluations of resident and family surveys of the activities programme show increased satisfaction since the previous audit. A monthly summary is completed for all residents related to the activities offered and comparisons are made with the previous month which includes review and evaluation of all the specific and individual events and activities that have occurred. There is documented evidence of the reasoning behind why these activities have or have not been supported. Residents who attend are documented, however a comment is also made about residents that did not participate and the reasons why, or why residents participated at different levels and what other options were explored and the outcome recorded.</p>	<p>The service is rated continuous improvement for the specific detail documented to show how activities are implemented to ensure all resident likes, dislikes and strengths are met. Specific detail is given to cultural activities to meet the cultural diversity of residents. Resident physical acuity levels and mental abilities are considered when activities are planned and presented. The activities plan is a living document and is changed to match resident needs. The resident satisfaction with activities is measurable in the resident and family satisfaction survey results.</p>

End of the report.