

Village at The Park Care Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Village at The Park Care Limited
Premises audited:	Village At The Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 9 March 2017 End date: 9 March 2017
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	81

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

The Village at the Park facility is one of four age care facilities owned by Hurst Lifecare Limited. The service provides care for up to 85 residents across three service levels (hospital, rest home and dementia). There were 81 residents living at the facility at the time of the audit.

This surveillance audit was conducted against aspects of the 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, family, management, staff and a general practitioner.

The service has addressed the previous audit finding around residents being able to access the nurse call bell system.

This audit has identified one improvement required around the completion of 24-hour activity plans for residents in the dementia unit.

The service has maintained a previously awarded continuous improvement rating around evidencing good practise.

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.

All standards applicable to this service fully attained with some standards exceeded.

A policy on open disclosure is in place. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

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.

Services are planned, coordinated and are appropriate to the needs of the residents. A general manager and an assistant manager/clinical leader are responsible for the day-to-day operations of the facility. Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A robust health and safety programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided 24 hours a day, 7 days a week. There are adequate numbers of staff on duty to ensure residents are safe.

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>
---	--	--

A registered nurse assesses and develops the care plan documenting support, needs, goals and outcomes with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were reviewed at least six-monthly by the multidisciplinary team. Resident files included review by the general practitioner, specialist and allied health services.

A diversional therapist oversees the activity team and coordinates the activity programme for the rest home, hospital and dementia level of care residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents and families report satisfaction with the activities programme. Residents are encouraged to maintain links with community groups.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines have completed medication competencies and annual education. The medicine charts reviewed meet prescribing requirements. The general practitioner reviews medications three-monthly.

Resident food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours.

Safe and appropriate environment

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

The building holds a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

Village at the Park has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there was one resident requiring the use of an enabler and five residents requiring the use of a restraint.

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.
---	--	--

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. The service benchmarks infection control data against other villages within the group.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	16	0	1	0	0	0
Criteria	1	39	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)
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 1.1.13: 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. Access to complaint forms and a suggestions box are located at reception. The complaint form includes contact details for the HDC Advocacy Service. A record of all verbal and written complaints received is maintained by the general manager using a complaint's register. Three complaints were received in 2016 and four made in 2017 year-to-date with evidence of appropriate and timely follow-up actions taken. Documentation including follow-up letters and resolution demonstrates that complaints are well-managed. An anonymous complaint made through the district health board (DHB) in 2016 had corrective actions implemented, which were followed up and closed off (sighted). Discussions with six residents (three rest home and three hospital) and five relatives (two rest home, two hospital and one dementia level of care) confirmed they were provided with information on complaints.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>Evidence-based practice was evident, promoting and encouraging good practice. Registered nursing staff are available 7 days a week, 24 hours a day. The service receives support from the district health board which includes visits from specialists (e.g., wound care, mental health) and staff education and training. Physiotherapy services are provided for four hours per week with additional support provided by a designated physiotherapy assistant. There is an education and training programme for staff that includes in-service training, support with literacy and numeracy skills and impromptu training at handovers.</p> <p>The service has evidenced that the previous continuous improvement rating awarded at certification audit has</p>

		continued to be implemented and evidences improved outcomes.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is documented on accident/incident forms. Fourteen accident/incident forms were reviewed across the rest home, hospital and dementia unit identified family were kept informed.</p> <p>Relatives interviewed stated that they are kept informed when their family member's health status changes. The Hurst Lifecare's 'Vision and Values' brochures and posters are visible and available throughout the facility. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement.</p> <p>The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Village at the Park facility is located in Wellington. It is one of four care facilities owned by Hurst Lifecare Limited. The service currently provides care for up to 85 residents across three services (hospital, rest home and dementia level of care). On the day of the audit, there were 39 of 42 hospital residents, 10 of 10 rest home residents and 32 of 33 residents residing in the secure dementia unit. All residents were under the Aged Related Residential Care (ARRC).</p> <p>Hurst Lifecare Limited has an organisational philosophy, which includes a vision and values statement and objectives. The quality plan objectives for the Village at the Park are linked to the organisation's strategies. The organisation has a strategic direction that has been communicated to staff. The 2016 quality plan objectives have been reviewed and updated (sighted). The general manager is the Spark of Life master practitioner for the Spark of Life programme.</p> <p>The general manager is a registered nurse (RN) who has been in this role for over seven years. The general manager has a Masters in Health Service Management. The general manager is supported by an assistant manager/clinical leader (who has been in the role for six weeks) and three unit coordinators. The general manager is also supported by a national quality advisor, who was present on the day of the audit. The general manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.</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>An established quality and risk management system is being maintained. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A system for document control is in place. Any new policies or changes to policy are communicated to staff, evidenced in meeting minutes and in interviews with staff (four caregivers, two RNs, two enrolled nurses (EN), three activities assistants and one cook).</p> <p>Key components of the quality management system include (but are not limited to): monitoring falls, medication errors, restraint use, pressure areas, infections, wounds and resident satisfaction. Monthly reports submitted to the national quality advisor and the chief executive officer provide a coordinated process between service level and the organisation. There are monthly accident/incident reports that break down the data collected across the rest home, dementia unit, hospital units and staff incidents/accidents. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>There is a health and safety programme in place with strategies implemented to promote staff wellness. The health & safety committee meet monthly. Infections and health and safety matters, such as staff accidents are discussed at the Quiche (quality, infection control and health and safety) meeting and then fed back to the monthly staff meetings. Resident meetings also occur monthly. The internal audit programme monitors key components of the service. If a target is not met or an area of non-compliance is identified, there is evidence of a corrective action plan.</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>Individual incident reports are documented for each incident/accident and are also documented in the residents' progress notes. Documentation includes the action taken and any follow up action required. Data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Fourteen completed incident forms were reviewed and reflected a clinical assessment and follow up by a RN. Discussions with the general manager and national quality advisor confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed (one assistant manager, two caregivers, two RNs and one activities assistant) included evidence of the recruitment process, signed employment contracts, police vetting and completed orientation programmes and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service. A register of current practising certificates for all health professionals is maintained.</p> <p>There is an implemented annual education schedule. Education for RNs is supported by the local DHB. Discussions with staff and management confirmed that a comprehensive education and training programme in relevant aspects of care and support is in place.</p> <p>There are 22 caregivers who work in the dementia unit. Nineteen of the caregivers have completed the required dementia standards. The three caregivers who have not yet completed the required dementia standards have been employed for less than one year and are enrolled in the dementia programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The general manager is an RN with a current practising certificate. Two unit coordinators/RNs are assigned to the dementia and hospital wings and one unit coordinator/EN is assigned to the rest home wing. There is another RN in the hospital also across am, pm & night shifts. An RN is available on-site 24 hours a day, 7 days a week. Caregivers are adequately staffed throughout the facility. Staffing is flexible to meet the acuity and needs of the residents. A casual pool of staff is available as needed. Interviews with six residents and five families confirmed staffing overall was satisfactory.</p> <p>The dementia unit is split into two units, Block A (15 beds/15 residents) where there were two caregivers on the am & pm shifts & one at night. Block B (18 beds/17 residents) there were three caregivers in the am & pm shifts & one at night. There is one RN across the dementia units on the am & pm shift.</p> <p>Four caregivers (two dementia & two hospital) were interviewed. Caregivers interviewed stated that there was sufficient staffing.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p>	<p>FA</p>	<p>Twelve medication files were reviewed (four rest home, four hospital and four dementia level of care). The service uses an electronic medication management system. The medication management policies comply with medication legislation and guidelines. All required medication checks had been completed. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication rooms.</p>

<p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>Medication administration practice complies with the medication management policy for the medication rounds sighted. Registered nurses and senior caregivers administer medicines. All staff administering medicines have been assessed as competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. Two RNs reconcile the delivery of new medication (two-weekly cycle) and document this. There was evidence of three-monthly reviews by the GP. All residents self-administering their own medication had completed the required competency assessments. Standing orders are not used.</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>The chef oversees the food services and is supported by kitchen staff on duty each day. The national menus have been audited and approved by an external dietitian. The main meal is at lunchtime. All baking and meals are cooked on-site in the main kitchen. Meals are delivered in insulated hot boxes to each kitchenette where they are served. The chef receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, cultural food choices, vegetarian, pureed and alternative choices for dislikes are accommodated. Residents interviewed reported that they were very satisfied with the menu, quality and presentation of the meals.</p> <p>In the dementia unit, there is evidence that additional nutritious snacks are available over 24 hours.</p> <p>End cooked food temperatures are recorded on each meal daily. Serving temperatures from bain-marie are monitored. Temperatures are recorded on all chilled and frozen food deliveries. Fridges and freezer temperatures are monitored and recorded daily. All foods are dated in the chiller, fridges and freezers. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained.</p> <p>Food services staff have completed food safety education 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>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is documented evidence that family members are notified of any changes to their relative's health including (but not limited to): accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident files.</p> <p>Adequate dressing supplies were sighted in the medication stock rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds (one ulcer, six skin tears, two boils and two surgical excisions of lesions). There were no pressure injuries on the day of audit. There was a range of equipment readily available to minimise pressure injury. Chronic wounds have been linked to the long-term care plans after three weeks. There was evidence of wound nurse specialist involvement in the management of a chronic wound (ulcer).</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management</p>

		<p>and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health.</p> <p>Monitoring occurs for weight, vital signs, blood glucose, pain, challenging behaviour, wounds, restraint, continence and two-hourly repositioning. Registered nurses review the monitoring charts and report identified concerns to the GP or nurse specialist as required.</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>	PA Low	<p>The activities staff provide an activities programme over five days each week. The activity plan is reviewed by a contracted part-time occupational therapist. There are three activity staff employed. One has a degree in social work and one is a qualified diversional therapist. The third activity coordinator (newly employed) has enrolled to complete the required dementia education modules. There are activities planned for the weekend that are delivered by caregivers. Caregivers in the dementia unit have been orientated to activities and deliver the planned programme over the weekend. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned for the day were displayed on noticeboards around the facility. An activity plan is developed for each individual resident, based on assessed needs. A 24-hour activity plan was not evidenced to be developed for all residents in the dementia unit. Residents were encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. A music therapist visits the facility and was observed interacting with the residents in the dementia unit on the days of audit. The service has a van that is used for resident outings. Residents in all areas were observed participating in activities on the days of audit. Resident meetings and surveys provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed were updated as resident's care requirements changed. Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Resident reassessments have been completed using interRAI for all residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan. Where progress is different from expected, the service responds by initiating changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>A current building warrant of fitness certificate is posted at the entrance to the facility.</p>

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Residents were observed to have a call bell placed within reach or a sensor mat was in place (where required). Residents who required the use of a call bell and sensor mat were observed to have a dual adapter in place which can accommodate the use of both call methods. The service conducted a call bell audit in September 2016 which evidences compliance. This previous audit finding has been addressed.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. Standardised definitions are used for the identification and classification of infection events. A registered nurse is the infection control coordinator and is responsible for infection control across the facility. Results of surveillance are acted upon, evaluated and reported to relevant personnel at the various meetings. The service benchmarks infection control data against other villages within the group.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. At the time of the audit, the service had one resident using an enabler and five residents requiring the

minimised.		use of a restraint.
------------	--	---------------------

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 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>The activities programme reflects the residents’ cognitive and physical abilities. Group activities reflect ordinary patterns of life and include planned visits to the community. Residents and families interviewed commented positively on the activity programme. During the audit, residents in the rest home, hospital and dementia unit were observed participating in quizzes, crafts and musical entertainment. Rest home and hospital files reviewed evidenced a detailed 24-hour activity plan had been completed. However, these were not evidenced to be completed in the two dementia files reviewed.</p>	<p>Two dementia files reviewed did not contain a 24-hour activity plan.</p>	<p>Ensure all residents in the dementia unit have a 24-hour activity plan completed.</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 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Quality initiatives implemented include links with Massey University to promote evidenced based practice, with a research partnership, investigating opportunities to enhance the induction programme and education for the facility's culturally diverse staff. The service identified that for 75% of staff employed at Village at the Park, English was not their first language. The service contracted an external company to deliver education on literacy and numeracy to staff.</p>	<p>The improved outcomes evidenced from quality initiatives implemented around staff induction and education on literacy and numeracy included: a 25% reduction in incidents in the work place, a 20% increase in staff attendance at staff meetings, exits from the service decreased from 56% in 2014/15 to 18% in 2016, a 50% increase (proactive role) in hazard reporting through increased awareness and improved compliance with internal audit outcomes.</p>

End of the report.