

Whitehaven Healthcare Limited - Glendale Retirement Home

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: Whitehaven Healthcare Limited

Premises audited: Glendale Retirement Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 24 May 2017 End date: 24 May 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: 32

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 |
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|  | 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 |
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| 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

Glendale Retirement Home (Glendale) provides care for up to 33 residents at rest home level care. On the day of audit, there were thirty two residents including two younger persons under long-term chronic health condition contracts. There were no respite residents.

Glendale has a business quality and risk management plan. Goals and objectives of the business are identified and reviewed annually. The manager has a long history with Glendale – having been a previous owner. The manager has been in this role since February 2015. The manager is supported by two registered nurses.

This unannounced surveillance audit was conducted against the relevant Health and Disability Standards and contract with the district health board. The audit processes included the review of policies and procedures, the review of staff and resident's files, observations and interviews with residents, family members, management, contracted general practitioner and staff.

The service has addressed the one finding from their previous audit around the approved evacuation scheme.

There were no shortfalls identified at this audit.

One continuous improvement rating around the activities programme has been achieved.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Open disclosure principles are implemented. Complaints processes are communicated to residents and families and the complaint register is up to date. Complaints management system complies with the Code. There have been no documented complaints since August 2015.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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Glendale continues to implement their quality and risk management system. An annual review of the quality programme and incident and accidents reports is completed and the outcome communicated to staff. Quality data is benchmarked by an external provider with similar size organisations.

Health and safety policies and procedures are implemented. The hazards and risk register was reviewed in 2017. Health and safety issues are discussed both at health and safety meetings and staff/quality meetings. There are procedures to guide staff in managing clinical and non-clinical emergencies and a registered nurse is on call at all times.

Annual resident and relative surveys are conducted annually with the most recent during 2016. Corrective actions and quality improvements have been implemented and communicated to families.

There are human resources management processes in place and annual performance appraisals are completed. New staff receive an orientation programme prior to their commencement of care to residents. A staff education programme is implemented.

Staffing levels and skill mix are appropriate for the service level to provide safe service delivery.

Continuum of service delivery

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| 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. |
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A registered nurse is responsible for each stage of service provision. The registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau. Care plans viewed in resident records demonstrate service integration. Resident files include medical notes by the contracted GP and visiting allied health professionals.

The diversional therapist provides a varied and interesting activities programme for the residents.

Medication policies comply with legislative requirements and guidelines. Staff responsible for administration of medicines complete education and medication competencies.

All meals are prepared on-site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents and family/whānau interviewed responded favourably to the meals provided.

Safe and appropriate environment

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| 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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A current building warrant of fitness is posted in a visible location. The fire evacuation scheme has been updated.

Restraint minimisation and safe practice

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| 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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. No restraint and no enablers were in use.

Infection prevention and control

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| 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 infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 18 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 1 | 43 | 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 |
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| <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>Complaints management system complies with the Code. A complaints register is maintained and there are no documented complaints since August 2015. The complaint process is discussed with the residents and their families at the time of entry to the home. Residents and families interviewed confirm they are aware of who to make a complaint to if required. Staff have training on advocacy and complaints management.</p> <p>The Ministry requested follow up against aspects of complaint related to resident's privacy, dignity and independence, including early morning showers. There were no identified issues in respect of this complaint.</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>In all four care plans reviewed, there was evidence of preferred time of personal cares before breakfast and two files preferred time was around 5.30 am and 6 am.</p> <p>Family members, residents, and staff interviews confirmed that staffing levels are sufficient to carry out their duties and RNs are available to support staff if they require further assistance. Staff interviewed were knowledgeable around elder abuse, negligence and the Code of Rights.</p> <p>Interviews with three residents confirmed that they have a choice of what to do with their day and have a right to refuse if they don't want to receive care and support in certain times. Interviews with residents and family members did not identify issues around the time of personal cares. Three residents and four family</p> |

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| | | members who may have been affected by this issue interviewed confirmed satisfaction with this area of service delivery. |
| <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>Ten incidents/accidents forms were reviewed. The forms include a section to record family notification. All forms reviewed document that family have been informed.</p> <p>A residents and relatives' satisfaction survey was undertaken during 2016 and an individual response given to residents and family members. Residents and family interviewed confirm open disclosure principles are implemented. Family are consulted and informed of incidents and accidents or a change in care provision.</p> <p>Education on open disclosure is provided and included as part of the consumer rights training. Staff confirm their understanding of open disclosure. Communication with relatives is documented in the residents' files.</p> <p>Interpreter services are available and offered to residents with English as a second language.</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>Glendale Retirement Home provides care for up to 33 residents at rest home level of care. On the day of audit there were 32 residents which included two residents under the long-term chronic health condition contracts. There were no respite residents.</p> <p>Glendale has a business quality and risk management plan. Goals and objectives of the business are identified and reviewed annually.</p> <p>The manager has a long history with Glendale – having been a previous owner. The manager has been in the role since February 2015. The manager is supported by two experienced registered nurses (RNs). The RN hours have been increased from 30 hours to 46 hours a week since the previous audit.</p> <p>The manager maintains weekly contacts with the owner and two-monthly reporting includes: quality activities; finance; occupancy data; and other business related issues.</p> <p>The manager has completed at least eight hours of professional development.</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</p> | FA | <p>Glendale continues to implement its quality and risk management system. Annual review of quality programme and incidents and accidents have been completed and outcomes of these communicated to staff. Quality data is benchmarked by an external provider with similar size organisations.</p> <p>Discussions with staff (two RNs, three caregivers, one diversional therapist (DT) and one cook) and review of meeting minutes, demonstrates staff involvement in quality and risk activities.</p> |

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| <p>reflects continuous quality improvement principles.</p> | | <p>Health and safety policies and procedures are implemented. The hazards and risk register was reviewed in 2017. Health and safety issues are discussed at both health and safety meetings and staff/quality meetings. There are procedures to guide staff in managing clinical and non-clinical emergencies and a RN is on call at all times.</p> <p>Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Corrective actions around falls prevention are implemented. Pressure injury preventions are also discussed with staff and training has been provided around pressure injury prevention</p> <p>Key components of service delivery are linked to the quality and risk management system. The internal audit programme is implemented. If an audit identifies shortfalls, required corrective actions are implemented and are signed off in a timely manner. A monthly summary of internal audit outcomes is provided to the staff through staff meetings for discussion.</p> <p>Policies and procedures are up to date including health and safety policies which have been reviewed to reflect the current changes in work place safety. Policies and procedures are discussed at the monthly staff meetings and staff who were unable to attend meetings, are required to read them and sign them off as read. Staff interviews confirms that staff are aware of any new/reviewed policies.</p> <p>The service collates accident/incident, health and safety and infection control data. Monthly comparisons, trends, graphs and benchmarking data are displayed for staff information.</p> <p>Annual resident and relative surveys have been conducted for 2016. The outcome of the survey has been fed back to participants and staff as evidenced in meeting minutes. An individual response was given to residents and family members, including corrective actions and quality improvements, if participants identified themselves on the survey.</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</p> | <p>FA</p> | <p>Incidents and accidents are recorded by staff, follow up is completed by RNs and signed off by the manager. Incident and accidents to both staff and residents are reported. Feedback is provided through the staff/quality meetings and health and safety meetings. An incident and accident register is maintained and benchmarked through an external benchmarking provider. Annual review of incident and accidents are completed which includes any corrective action to minimise risks or prevent the incident from recurring.</p> <p>Accidents/incidents are also recorded in the resident progress notes. RNs are notified of incidents that</p> |

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| <p>affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | | <p>occurred after hours and required follow up is noted in the resident's notes. There is documented evidence the family have been notified promptly of incidents/accidents.</p> <p>Discussions with the manager confirms an 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 comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (two RNs, three caregivers and one cook). They all included: an orientation, training records and competencies. Annual performance appraisals have been completed in five out of six files reviewed and one was not due.</p> <p>A register of RNs, general practitioners (GPs), podiatrist, pharmacist and a clinical nurse practitioners' practising certificates are kept within the facility indicating that all relevant providers have a current practicing certificate.</p> <p>Glendale has an orientation/induction programme that provides new staff with relevant information for safe work practice. Three caregivers interviewed confirm that an appropriate orientation programme is implemented, including being buddied by another caregiver and review of policies and procedures.</p> <p>Annual training programme is implemented and it exceeds eight hours annually. One of the RNs provides internal training to staff along with external experts. The RN has completed wound care training and e-learning around infection control. The manager confirms there is nurse practitioner and nurse specialists input from the local DHB if required.</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>Staffing roster provides sufficient staffing covering for the provision of care and service to residents. There are two RNs. One works 30 hours a week and she is an interRAI competent RN. The second RN was employed in December 2016 for 16 hours a week. She is an experienced aged care RN. These two RNs share on call duties. The manager is on-site full-time and available after hours. The manager has 24 years of experience in managing aged care facilities.</p> <p>Staffing are rostered as follows: AM – two full shifts and one from 7 am-1 pm; PM- two full shifts and one tea assistant from 4 pm-7 pm; night- two caregivers. Cook works 8 am-2 pm and cleaner works 9.30 am -1.30 pm. There is an enrolled nurse (not maintaining her registration) who works 16 hours a week in rotating schedule where needs arise and she also supports one of the RNs when she is on call.</p> <p>Three caregivers, six residents and four family members interviewed confirmed that sufficient staff are rostered for each shift.</p> <p>The Ministry requested follow up against aspects of a complaint that included early morning showers. There</p> |

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| | | were no identified issues related to staffing in respect of this complaint. |
| <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> | FA | <p>The medication management system includes a medication policy and procedures that meets recognised standards and guidelines for safe medicine management. Twelve medication charts were reviewed. All residents have individual medication charts with photo identification, allergy status documented and meet legislative prescribing requirements. The service uses a four-weekly blister pack system for tablets. All medicine is stored securely when not in use. A reconciliation check is completed by the RN against the resident's medicine order, when new medicines are supplied from the pharmacy. Medication orders include indications for use of 'as needed' medicines. Eye drops and ointments are dated once opened.</p> <p>All staff (RNs and senior caregivers under supervision of an RN) who administer medications have been assessed for competency on a yearly for RNs and six-monthly for senior caregivers. Education around safe medication administration has been provided. One caregiver was observed to be administering medications and followed correct procedure. Staff interviewed described their role in regard to medicine administration. Standing orders are not used. There was one resident self-medicating on the day of audit. All the necessary self-medication assessments and consents have been completed. Residents/relatives interviewed state they are kept informed of any changes to their medications.</p> <p>The medication fridge temperatures are recorded regularly and these are within acceptable ranges.</p> <p>The medication charts reviewed identify that the GP has seen and reviewed the resident's three-monthly.</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> | FA | <p>All meals at Glendale are prepared and cooked on-site in a fully equipped kitchen. There is a five-weekly seasonal menu which has been reviewed and approved by a dietitian. Meals are delivered to the dining area for serving. A tray service is available upon request. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines.</p> <p>Supplements and high protein snacks and drinks are provided to residents with identified weight loss. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed are satisfied with the meals and confirm that alternative food choices are available.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Food is stored correctly.</p> <p>All staff working in the kitchen have completed training in food safety and hygiene and chemical safety.</p> |

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| <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 RN initiates a review and, if required, GP or nurse specialist consultation. The family members confirmed on interview they 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.</p> <p>In the residents' files reviewed, short-term care plans have been commenced with a change in health condition and linked to the long-term care plan. Long-term care plans have been reviewed six-monthly. The interRAI assessment process informs the development of the care plan.</p> <p>Continence products are available. Resident files include a urinary continence assessment, bowel management and continence products identified. The RN was able to describe access for wound and continence specialist input as required.</p> <p>Specialist nursing advice is available from the DHB as needed. A falls risk assessment is completed on admission and reviewed at least six-monthly or earlier, should there be an increased falls risk. A physiotherapist referral to the community physiotherapy service can be initiated as required.</p> <p>A clinical pharmacologist from the local PHO supports the GP and Glendale around polypharmacy and drug interactions. The GP gave examples and discussed several learnings and improvements in medicine prescribing.</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> | <p>FA</p> | <p>A diversional therapist (DT) typically works a minimum of 30 hours per week Monday to Friday. DT hours are flexible and allow for attendance at organisation of special events at weekends and evenings, according to resident wishes. Volunteers and caregivers assist with individual and group activities during the week and on weekends. One volunteer runs a male focus group.</p> <p>The activities programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The monthly programme includes: crafts, van outings, church services, games, gardening and happy hour. Recently four residents went out to see a film and twenty-five residents are going on a train trip. A group of residents attend exercise classes and groups in the local community. On the day of audit, residents were observed participating in a variety of activities. One-on-one activities are provided for residents who are unable or choose not to be involved in group activities. There was evidence of one resident who initially did not participate in activities who now participates and is leading an art project in the home.</p> <p>The DT is responsible for the resident's individual activity care plans which are developed within the first three weeks of admission. The resident and family/whānau are involved in the development of the activity plan. Resident files reviewed identify that the individual activity plan is reviewed six-monthly and evidence</p> |

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| | | <p>outcomes achieved against goals set.</p> <p>Activities are planned that are appropriate to the functional capabilities of residents and are mostly driven by resident requests. Residents provide feedback individually and make suggestions for activities at the resident meetings and via annual resident satisfaction survey.</p> <p>Residents and families interviewed report satisfaction with the activities programme. Glendale demonstrates continuous improvement in delivery of their activities programme.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>In the files sampled, initial care plans have been evaluated by RNs within three weeks of admission. The long-term care plans are evaluated at least six-monthly or earlier if there is a change in health condition. There was at least a three-monthly review by the GP. All changes in health status are documented and followed up. Short-term care plans have been evaluated and resolved or added to the long-term care plan if the problem is ongoing. 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> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>A current building warrant of fitness is posted in a visible location (expiry 14 December 2017). Reactive and preventative maintenance occurs.</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> | FA | <p>The last fire evacuation drill was completed 16 August 2016. Glendale has an up-to-date fire approval scheme dated 16 August 2016. The previous shortfall around all areas having a fire evacuation approval has been addressed.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p> | FA | <p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified</p> |

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| <p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | | <p>and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>There have been no outbreaks since the previous audit. Outbreak management was discussed with both RNs, including notification protocol to the Public Health Authorities. Both RNs were up to date with current expectations from the Public Health Authorities. Staff receive ongoing training and support and RNs ensures that infections are prevented and managed both for staff and residents. Visitors are encouraged to not visit when they are unwell and to use hand sanitisers.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>Restraint minimisation is practiced. The registered nurse oversees the restraint process within the facility. There are policies around restraint, enablers and the management of residents who may exhibit behaviours that challenge. The service currently has no residents using enablers or restraints. Any resident requiring restraint or who exhibited behaviours that may challenge, would be reassessed to determine their suitability to continue to reside in the rest home.</p> |

Specific results for criterion where corrective actions are required

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

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

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

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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 |
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| <p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | CI | <p>The service provides an environment where resident choice is paramount and underpins the activity programme. There is evidence of increased satisfaction with the activities programme offered.</p> | <p>A diversional therapist is on-site for a minimum of 30 hours per week. She is flexible with her hours and covers weekends and evening activities. She has implemented a range of activities at resident’s request. A focus has been on supporting residents to maintain and grow their interests and be involved with their local community. The DT coordinates an activities programme which provides individual and group activities that are meaningful and reflect ordinary patterns of life.</p> <p>There was evidence of support with organisation and attendance at activities over and above the normal programme offered. There are van outings at least twice a week of resident choice. School groups, local choir and church groups visit. One volunteer runs a male focus group and two residents have contributed to a project to support animals (chickens, ducks and guinea pigs). Two residents have taken on the responsibility of looking after the animals and report great satisfaction by doing this. One resident interviewed attends the gardens and reports how happy they are to be able to provide a colourful garden for other residents to enjoy. Recently four residents went out to see a film and twenty-five residents were participating in a train trip and pizza.</p> <p>Residents are encouraged to maintain their interests they had prior to admission and some residents attend exercise classes and groups in the local community. There was evidence of</p> |

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| | | | one resident who initially did not participate in activities, now participates and is heading an art project in the home. A ladies' knitting group knit blankets that are sent to charities of resident's choice. One of the male resident's who used to hold the wool for his wife, continues to do this in the knitting group. |
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End of the report.