

Dementia Specialists Limited - Brooklands Rest Home

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: Dementia Specialists Limited

Premises audited: Brooklands Rest Home

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 15 June 2017 End date: 16 June 2017

Proposed changes to current services (if any): The service has changed the bed status from 16 rest home and 12 secure dementia care to 14 rest home and 14 secure dementia care. The total number of beds available has not changed just the configuration of services.

Total beds occupied across all premises included in the audit on the first day of the audit: 24



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

Dementia Specialists Limited – Brooklands Rest Home and Memory Lane provides rest home level care for up to 28 residents, with 14 beds being dedicated secure dementia care beds. The service is privately owned and the management team consists of the owner/director, business manager, facility manager and clinical manager (registered nurse).

The service has reconfigured the bed numbers from 16 rest home and 12 secure dementia care to 14 rest home and 14 secure dementia care. This has not changed the total capacity of the service which is 28 beds in total. Residents and families spoke positively about the care provided.

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 review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management and staff. The general practitioner was not available for interview.

This audit has resulted in a continuous improvement in good practice and identified two areas for improvements relating to human resources management and incomplete documentation.

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.

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services providers support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. The Brooklands Rest Home and Memory Care units are based on a resident centred model of care/service delivery that focuses on the resident's normal lifestyle choices.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk management plans include the scope, direction, goals, values and philosophy of the organisation. Monitoring of the services provided to the governing body is regular and effective. There is an experienced and suitably qualified management team in place with clinical care being overseen by the clinical manager who is a registered nurse.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff which is based on current good practice is reflected in policy. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

The service has a resident information management system in place which is appropriate to the service type and setting.

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.
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Access to the service is appropriate and efficiently managed with relevant information provided to the potential resident/family.

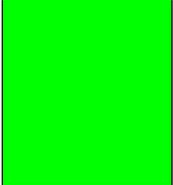
Residents' needs are assessed on admission, with reassessment occurring at least six monthly. Care plans/lifestyle plans are individualised, based on a range of information and accommodate any new problems that might arise. The files sampled demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

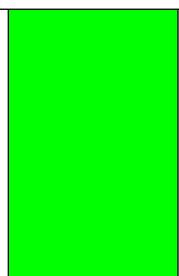
The reconfiguration of the service did not require any change to the fire evacuation procedure as fire cells remain unchanged. Staff are trained in emergency procedures, use of emergency equipment and supplies, and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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 organisation has implemented policies and procedures that support a restraint free environment. The service was restraint free at the time of audit. All documents for assessment, approval and monitoring processes are available, should restraint or enablers be used. Policy states that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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 infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. Surveillance data is compared against aged care benchmarking rates.

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	42	0	2	0	0	0
Criteria	1	90	0	2	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Brooklands Rest Home and Memory Care has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation and in ongoing training.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. The resident's files sampled show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's records. Staff were observed to gain consent for day to day care and encouraged the residents to be as independent as possible with their care.
Standard 1.1.11: Advocacy And	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were

<p>Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>		<p>also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</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>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the philosophy of normalisation of family and community participation (also refer to 1.1.8).</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and complaints forms are on display at the facility. Families and residents confirmed they know the processes to undertake to make a complaint. All complaints are assessed using a documented risk assessment matrix.</p> <p>The complaints register reviewed showed that three complaints have been received over the past ten months (since the current owner purchased the facility) and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The facility and clinical managers are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and families reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service as part of the admission information provided and in discussions with staff. The Code and information on advocacy services is displayed at the entrance, this also includes information on how to make a complaint and provide feedback.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by going to community activities and participation in clubs of their choosing. The care plans/lifestyle plans included documentation related to the resident's abilities, and strategies to maximise independence. The philosophy of the rest home and dementia unit (Memory Lane) incorporated the organisational philosophy of person centred care and services that maximise the resident's independence, abilities and self-worth.</p> <p>Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</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>	<p>FA</p>	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. There are no current residents who identify as Māori, with management reporting there are no known barriers for Maori accessing the service.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans sampled of resident from other countries. The resident and family satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	<p>FA</p>	<p>Residents and family members stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction and ongoing education programmes include education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process</p>

other exploitation.		they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	CI	<p>The service encourages and promotes good practice through a specific model of care related to residents living with dementia. The person centred approach, though developed for dementia level of care, is incorporated into the service delivery across the service, including the rest home residents. Residents are encouraged with independence and meaningful activities.</p> <p>The policies and procedures are evidence based. The residents have input from external specialist services and allied health professionals, for example, hospice/palliative care team, wound care specialist, psychogeriatrician and mental health services for older persons. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents being able to speak English or staff able to provide interpretation as and when needed. The service has appropriate communication strategies for residents living with cognitive impairment.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>The strategic and business plans, which will be reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the owner/director showed adequate information to monitor performance is reported including occupancy, financial, staff retention, adverse events, health and safety, emerging risks and issues. The facility manager and the owner/director have a formalised weekly conference call which was confirmed in minutes sighted. Daily informal phone calls are made to the owner/director to ensure they are kept up to date on the day to day activities at the facility.</p> <p>The service is managed by a business manager, clinical manager who is a registered nurse, and a facility manager. All members of the management team hold relevant qualifications. The clinical manager has worked at the facility since November 2016, firstly as the clinical nurse leader and then</p>

		<p>as the clinical manager since May 2017. Responsibilities and accountabilities are defined in a job description and individual employment agreement. Members of the management team and the owner/director confirmed knowledge of the sector, regulatory and reporting requirements. All members of the management team maintain their knowledge via ongoing education, both clinical and non-clinical, according to their roles.</p> <p>There is 24 hour registered nurse cover on call process in place which the clinical manager stated is sustainable with assistance from an experienced casual registered nurse who undertakes this process as required.</p> <p>The service holds an Age Related Residential Care (ARRC) contract with Taranaki District Health Board (TDHB) for rest home level care including secure dementia care and respite care. All 24 residents were receiving services under the ARRC contract (13 secure dementia care and 11 rest home level care) at the time of audit. There were no respite care residents at the time of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the business manager is absent, the role is undertaken by the owner/director. When the facility manager is away, the clinical manager and business manager share the required duties under delegated authority. During absences of the clinical manager, the role is undertaken by a casual relief registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise (This person is the previous clinical manager who resigned to work in a different area of health). Staff reported the current arrangements work well.</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 planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular resident and family satisfaction survey, monitoring of outcomes, clinical incidents including infections and health and safety.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meeting and staff meetings. Staff reported their involvement in quality and risk management activities through internal audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. For example, when resident falls increased, a full review was undertaken and it was noted one resident was having multiple falls. Actions documented included the use of non-slip socks and hip protectors, a GP medical review, physiotherapy input and review of the walking equipment, family involvement</p>

		<p>and education related to the need to use a walking frame at all times. A sign was placed on the resident's walking frame and on the wall above the bed reminding the resident to 'take me with you' as a visual prompt. This has resulted in a reduced number of falls for the resident.</p> <p>Resident and family satisfaction surveys have been undertaken. The most recent survey undertaken in February 2017 showed that a corrective action was undertaken related to residents wishing to have more gravy and sauces with their meals. This has resulted in a full array of condiments, including gravy, being provided with main meals, which residents can use to their liking.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. All interRAI assessments are undertaken by the clinical manager. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The management team described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The business and facility managers are familiar with the Health and Safety at Work Act (2015) and have implemented requirements. A current risk register was sighted.</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>Staff document adverse and near miss events on an accident/incident form. A sample of accident/incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the management team including the owner/director.</p> <p>The facility manager and clinical manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner's inquests, issues based audits, and any other notifications since the previous audit.</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</p>	<p>PA Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained.</p> <p>Documentation related to staff orientation includes all necessary components relevant to the role. With the exception of two staff, it was reported that the orientation process prepared staff well for their role. Six of seven staff records reviewed show documentation is not fully completed to show that</p>

<p>of legislation.</p>		<p>all aspects of the orientation process have been undertaken by each staff member. Performance reviews have been undertaken after a three-month period and occur annually thereafter.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff working in the dementia care area have either completed or are enrolled in the required education. The clinical manager (RN) is trained and competent to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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 a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. The on-call is undertaken by the clinical manager for clinical matters and the facility manager deals with non-clinical issues. The casual RN relieves the clinical manager for on-call as required. Care staff reported there were adequate staff available to complete the work allocated to them.</p> <p>Residents and family interviewed supported this. Observations and review of four weeks rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. The clinical manager works on-site Monday to Friday.</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>	<p>PA Low</p>	<p>All necessary demographic and personal information was completed in the residents' files sampled for review. Clinical notes were current, with reference made in the resident's file or care plan regarding any related forms (such as behaviour monitoring, wound treatment plans and short term care plans). The residents' files contained records from the GP, allied health or another external service provider. The residents' records sampled included interRAI assessment information entered. The progress note records were legible with the name and designation of the person making the entry identifiable in most instances. There is an overall improvement required in the completing of care and staff forms and documentation.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>	<p>FA</p>	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC or GP for residents accessing respite care. There were no resident receiving respite care at the time of audit.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed assessments and signed admission agreements in accordance with contractual requirements.</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>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses a transfer form to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed the transfer form and discharge information from the acute care hospital when the resident returned to the service. Family of the resident reported being kept well informed during the transfer of their relative</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 medicine management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medicines are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medicines against the prescription. All medicines sighted were within current use by dates.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge were recorded daily.</p> <p>Best practice prescribing practices were noted and include the prescriber's signature and date</p>

		<p>recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three monthly GP review was consistently recorded on the medicine chart. Standing orders are used, were current and complied with guidelines. There is an implemented process for comprehensive analysis of any medicine errors.</p> <p>All staff who assist with medicine management have a current competency assessment. There were no residents who self-administered medicines at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>The changes to reconfiguration of the service has not had any impact on the medicine management system.</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 food service is provided on site by an external contractor/qualified chef/cook and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the Memory Lane have unrestricted access to food and fluids to meet their nutritional needs. Though there are ranges of meal times, residents in both the rest home and memory care may eat at whatever time suits them. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by residents and family members interviewed, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Though there are ranges of meal times, residents may eat at whatever time suits them.</p> <p>The changes to reconfiguration of the service have not had any impact on the kitchen services. The main kitchen remains in the same location, with the kitchenette in Memory Lane being able to cater for the additional two residents.</p>

<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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. The service maintains a waiting list for potential residents. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as (pain scale, falls risk, skin integrity, nutritional screening, challenging behaviours and depression scale), to identify any deficits and to inform care planning. The sample of lifestyle plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in lifestyle plans sampled.</p> <p>The lifestyle plans evidenced service integration with progress notes, activities notes, with medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of service delivery.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and their plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The staff interviewed verified that medical input is sought in a timely manner, and supporting the resident is based on the resident's individual needs and capabilities. Care staff confirmed that care was provided as outlined in documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p>	FA	<p>In addition to the planned activities, the resident is encouraged to participate in meaningful 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>throughout the day and night. The activities programme is provided by an activities coordinator, with input from other staff, volunteers and residents assisting with the planned and spontaneous activities.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the activities meaningful to themselves.</p> <p>Activities for residents living in Memory Lane are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. As part of the normalisation philosophy at the service, many activities include both rest home and residents living in Memory Lane.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds and pain management.</p> <p>When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Residents may choose which medical practitioner they use. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to oncology and general surgery. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if needed.</p>

to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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 (expiry date 02 August 2017) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with management and observation of the environment. The environment was hazard free, residents were safe and independence was promoted.</p> <p>There is a documented maintenance book which showed any maintenance requests made were actioned promptly. This was confirmed during staff interviews.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. There are appropriate secure outdoor areas for residents in the secure dementia unit.</p> <p>Residents confirmed that they were happy with the environment.</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>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes separate staff and visitor toilet facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. The bathrooms have been updated and an additional bathroom installed in the secure dementia care wing as part of the increase of two beds in this wing.</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>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. At the time of audit, all bedrooms were single occupancy. Management confirmed that the double bedroom in the secure dementia care unit and three double bedrooms in the rest home will only be used with consent of the residents and/or family. Rooms are personalised with furnishings, photos and other personal items displayed. As part of the refurbishment process, residents were asked to choose their own bedroom wallpaper.</p> <p>The bedrooms which have been converted from rest home to secure dementia care occurred by moving the locked door from one existing wall to another wall. It is a natural continuation of the existing secure dementia unit. No changes were required to the fire evacuation process.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. Activities were sighted in both lounge areas at the time of audit. The dining and lounge areas enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> <p>The lounge/dining area in the rest home has been reconfigured to accommodate the use of the two existing bedrooms to become part of the secure dementia care unit. It remains spacious enough to cater for 14 rest home level care residents.</p> <p>The lounge/dining area in the secure dementia care unit is open plan and caters for up to 14 dementia care residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site in a dedicated laundry area as part of the care staff duties. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Cleaning is undertaken as part of the care staff daily duties. Management stated this is currently under review and a letter sighted explaining the proposed process had been sent to all staff. Staff education related to safe chemical handling is undertaken by the off-site chemical provider, last presented in March 2017. Chemicals were stored in secure areas and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and resident</p>

		and family feedback.
<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>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 02 March 1988 and there have been no changes to the building footprint since this time. Management confirmed they checked with the fire service about the need to update the evacuation plan related to the secure dementia care unit and no changes were required. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 10 April 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 28 residents. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff responded promptly to call bells.</p> <p>Doors and windows are locked at a predetermined time by staff on duty. The external doors in the secure dementia care unit are alarmed during the night only to alert staff if a resident goes outside.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Heating is provided by ceiling mounted electric heaters controlled by a thermostat. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme and manual are reviewed annually as part of the internal audit programme.</p> <p>The clinical manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results and key performance</p>

<p>the size and scope of the service.</p>		<p>indicators are reported monthly to the director, and tabled at the quality meeting. This committee includes representatives from all staff.</p> <p>The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role. They have attended specific education related to infection prevention and control.</p> <p>Additional support and information is accessed from the infection control team at the DHB, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by an infection prevention and control consultancy agency. Policies were last reviewed in 2017 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and</p>	<p>FA</p>	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the IPC coordinator and external specialists. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that</p>

<p>consumers.</p>		<p>additional staff education has been provided in response. For example, when an increase in infections occurred, additional education was conducted on urinary tract infections,</p> <p>Education with residents is generally on a one-to-one basis and has included subjects such as encouraging fluids, reminders about handwashing, and advice about remaining in their room if they are unwell.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs, with short term care plans developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Data is benchmarked against recognised guides for aged care. Where there has been an increase in infections, corrective actions are implemented. An example of this was when there was an increase in urinary tract infections, and a corrective action plan was implemented. No infections were recorded in the subsequent months.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator (RN) stated they would provide support and oversight for enabler and restraint management should it be used. They demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the days of audit, the facility was restraint and enabler free. The last use of any form of restraint shown in the restraint register occurred in 2015. Policy states that enablers should be the least restrictive and used voluntarily at the request of the resident.</p> <p>Staff and management stated that restraint would only be used as a last resort when all alternatives have been explored. Staff education and a questionnaire related to safe restraint use was completed by 16 clinical staff in May 2017.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	The service has an orientation/induction programme documented which covers the essential components of the service provided. Most staff interviewed confirmed their orientation/induction period prepared them for the roles they undertake. Two staff stated that they had a very short orientation which only covered emergency procedures and then they were counted as a rostered staff member. Both staff had worked in the health care arena previously and were experienced caregivers. They stated that they were able to undertake their roles safely and they were ‘buddied’ with another experienced caregiver. Incomplete sign off of staff orientation documentation supports the staff interview findings.	Not all new service providers have their orientation/induction completed. Six of seven staff files reviewed had incomplete documentation to show that orientation had been completed.	Provide documented evidence that all new staff have completed the orientation/induction process. 180 days
Criterion 1.2.9.1 Information is entered into the consumer information	PA Low	The resident files reviewed had several forms related to bowel and pain management that were not fully completed. There was inconsistent terminology and abbreviations used in the forms and progress notes. There was an inconsistent use of, and unclear definition of the pain scales that are recorded in the residents’ progress notes. Some of the	Forms related to resident care/interventions, environment recordings and staff	Provide evidence that information is entered consistently and accurately into records.

<p>management system in an accurate and timely manner, appropriate to the service type and setting.</p>		<p>forms related to medication management interventions and fridge temperature records were not fully completed. All progress notes sampled contained the date, time and name/signature of the person making the entry, though one staff member consistently did not write their designation. In six of the seven staff files sampled the recruitment, orientation and training records was not fully completed (also refer to 1.2.7.4).</p>	<p>orientation records were incomplete</p>	<p>180 days</p>
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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, there 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>Brooklands Rest Home and Memory Care has been recognised at the national level for the implementation of Hogeweyk, a resident centred social approach to service delivery. The design, decoration and daily living activities inside and outside the home are tailored to create a familiar and normal lifestyle for the residents. The residents are encouraged with their independence and participation in activities that they have normally participated in. This has resulted in the reduction of challenging behaviours, with the residents being supported to attend previous community activities (such as volunteer work, clubs and external exercise programmes). The service has also evidenced that with the reduction in challenging behaviours, the partners and families of the residents could engage in more frequent and meaningful relationships. The families and staff also reported increases in resident happiness and self-worth, with the</p>	<p>The achievement of implementing the organisational philosophy of dementia care, in both the memory care unit and the rest home, is rated beyond the expected full attainment. The service’s approach and philosophy is gaining positive results in the reduction of challenging behaviours and increasing ‘normal’ community and family participation with the residents. The service has conducted a continuous quality improvement plan since the opening of the memory care unit with improvements in the education programme, increased staff knowledge, and confidence and skill in assisting residents with their independence and community/family participation. With the model of care and philosophy implemented at the service, the projects have a documented review process which includes the analysis and reporting of findings. Improvements in individual resident reduction in challenging behaviours, participation in ‘normal’</p>

		<p>residents participating in activities that they have previously enjoyed, such as mowing lawns, mechanical repairs, gardening, looking after animals and daily household duties. This participation is decreasing the number and severity of challenging behaviours that the residents had previously exhibited.</p> <p>Several individual examples were evidenced on how residents that were at increased risk of admission to higher care psychogeriatric care could be effectively cared for at Brooklands. Brooklands is continuing to report positive outcomes for residents with dementia, their family/whānau and staff through the implementation of their model of care.</p>	<p>activities of daily living and increased connection with family and community have been measured as part of the care evaluation processes. The overall quality improvement project includes documenting that positive outcomes have been measured through staff, resident and relative satisfaction surveys.</p>
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End of the report.