

Heritage Lifecare Limited - Colwyn House

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:	Heritage Lifecare Limited
Premises audited:	Colwyn House
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Dementia care
Dates of audit:	Start date: 9 January 2018 End date: 10 January 2018
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:	60

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
	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
	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

Colwyn House provides psychogeriatric, medical and geriatric hospital level care as well as dementia level care for up to 69 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager. Families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the services contract with the Hawke's Bay District Health Board. The audit process included review of policies and procedures, review of residents` and staff records, observations and interviews with family members, management, staff, a general practitioner and the quality coordinator. Residents spoken with by the auditors provided limited information, given their cognitive abilities.

There were no areas identified as requiring improvement. There was one area related at a continuous improvement level (excellence rating) for the activities programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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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 and care provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. There was no evidence of abuse, neglect or discrimination.


Open communication between staff, residents and families is promoted, and 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 and act on any advance directives.

Residents who identify as Māori, or other cultures, have their needs met in a manner that respects their individual cultural values and beliefs.

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

The facility manager is responsible for the management of complaints and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility and is supported by the clinical service manager.

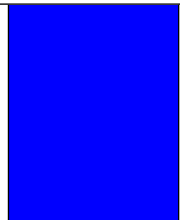
The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with

corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

There is no resident information of a personal nature on display. Records maintain confidentiality and are securely stored.

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.		All standards applicable to this service fully attained with some standards exceeded.
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Entry to the service is clearly defined in policies. If a potential resident is declined entry to the service, this is recorded and the referrer informed.

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital and rest home level care. Staff are qualified to perform their roles and deliver all aspects of service delivery. All residents are assessed on admission and assessment details are retained in the individual resident's record.

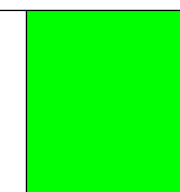
The residents' lifestyle plans document the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The service uses a mix of electronic and paper based assessment tools. The residents, and where appropriate the family/whanau, are involved in the lifestyle planning and review.

The activities available are appropriate for residents requiring hospital and rest home level care, including the needs of younger people under the age of 65. The programme is a strength of the service and meets the interests of the residents.

The service has implemented a web based medication management system that complies with current legislation. Staff who assist in medication management are assessed as competent to perform their role.

The menu plans have been reviewed by a dietitian. Each resident is assessed on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. The kitchen has a registered food safety plan that complies with current food safety legislation and guidelines.

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 was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal 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.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. A call bell system is in place. Security is maintained for the environment and the individual secure wings of the facility due to the nature of the services provided.

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 the minimisation of restraint. No enablers are used. Eight restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff interviewed demonstrated a sound knowledge and understanding of the restraint process.

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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There is a documented and implemented infection control programme which is appropriate to the service. The plan and outcomes are reviewed annually. Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies reflect current accepted good practice and were readily available for staff. The DHB, or other specialised input, is sought as required.

Infection control education is provided by the infection control coordinator or external specialists, who have current knowledge of best practice. The staff education is relevant to the service setting.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	49	0	0	0	0	0
Criteria	1	100	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the in-service and online education programmes. Residents' rights are upheld by staff (eg, staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The family/whānau reported that residents are treated with respect and dignity.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring, where applicable, this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. An advance directive and advance lifestyle plan are used to enable residents and family/whānau to choose and make decisions related to end of life care. The files sampled that had current advance directive that</p>

		<p>were made when the resident was competent to do so, have signed advance lifestyle plans that identify residents' wishes and meet legislative requirements</p> <p>Family/whanau and where appropriate, the resident (as much as possible, dependent on the resident's level of cognition and capacity), are included in care decisions.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whanau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff interviewed reported knowledge of residents' rights and advocacy services.</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>	FA	<p>Residents reported they are supported to be able to remain in contact with the community through outings and walks. Policy includes procedures to be undertaken to assist residents to access community services and a mobility van is available. The activities programme involves linking with other aged providers and support services for the younger residents.</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>	FA	<p>The complaints policy and procedure and associated forms are documented and meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents/family/whanau on admission and those interviewed understood how to do so. The service has not received any external complaints such as police, coroner's cases or Health and Disability Commissioner complaints since the last audit. The complaints register was reviewed. There were two complaints documented in the register which have been addressed and closed out, dated and signed off by the facility manager. Complaints are reported weekly to the regional operations manager and to the national quality manager. All information is collated and complaints are used for improvement of service provision.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Policy details that staff will be provided with training on the Code and that residents will be provided with the Code information on entry to the service. Copies of the Code and other information related to rights are in the residents' rooms and displayed throughout the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families, as confirmed by interview with the clinical staff. Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (eg, with the resident and family/whānau in their</p>

		room). Family/whanau report that the residents are addressed in a respectful manner that upholds their rights.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The service has several younger people and their independence and links with the age appropriate community resources is encouraged. The resident's files sampled evidenced that the individual values and beliefs of the residents are respected. There were no concerns expressed by the family/whānau about abuse or neglect. Staff interviewed report knowledge of residents' rights and understand dignity, respect and what to do if they suspected the resident was at risk of abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery and decision making is sought if applicable. The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau.</p> <p>There were residents who identify as Maori at the time of audit, with the service meeting the resident's individual needs. Management reported that there were no known barriers to Maori accessing the services.</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>	FA	<p>The cultural and/or spiritual needs of the resident are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific health issues and food preferences are identified on admission. The lifestyle plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Family/whānau reported their relative's individual cultural, values and beliefs are met. Staff confirmed the need to respect the individual culture, values and beliefs of residents.</p>
Standard 1.1.7: Discrimination	FA	Family/whanau reported that residents were free from any type of discrimination, harassment or

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>exploitation and felt safe. The induction process for staff includes 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 they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals. The service has access and support from visiting specialist nurses and mental health teams. The general practitioner (GP) visits the service at least weekly. The GP reports that the service excels at picking up early warning signs of deterioration and implementing end of life care, as well as the management of residents with challenging behaviours. Family/whānau' satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included quality projects into the activities programme management and the web based medication management system.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Family/whānau 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 know how to access interpreter services, although reported this was rarely required due to all residents being able to communicate effectively in English or sign language. There are communication strategies in place for residents with cognitive impairment or use non-verbal means of communication.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of</p>	<p>FA</p>	<p>The strategic and business plans are now documented on the template provided by Heritage Lifecare Limited and the goals are personalised for Colwyn House Lifecare for 2017 - 2018. The business plan objectives cover operation objectives, continuous quality improvement, administration processes, capital expenditure and site specific objectives. The values, scope, direction and goals of the organisation are clearly documented in the business plan and displayed in the entrance to the facility.</p>

<p>consumers.</p>		<p>Action plans are included for each individual objective. The facility manager reports weekly and monthly as per reports reviewed to the governing group who monitor performance across the organisation, including emerging risks or any issues arising.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role since October 2017. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing business and management training. The clinical service manager works collaboratively with and supports the facility manager.</p> <p>The service holds contracts with the Hawke`s Bay District Health Board (HBDHB) for hospital geriatric and medical, hospital psychogeriatric and rest home dementia care, palliative care and younger persons disabled (YPD) under 65). On the day of the audit there were (20) rest home level dementia residents (including one YPD). The total beds available are 69 and 60 beds were occupied on the day of the audit. One palliative care (hospital level medical), and 39 hospital level psychogeriatric residents (including one psychogeriatric YPD under 65).</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 facility manager is absent, the clinical services manager carries out all the required duties under delegated authority with support from the regional operations manager and support office personnel. During absences of key clinical staff, the facility manager and the quality coordinator are able to take responsibility for any clinical issues that may arise as both staff have current annual practising certificates which were sighted. 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 the management of incidents and complaints, audit activities as reviewed and a regular patient satisfaction survey, monitoring of outcomes, and clinical incidents including infections. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and registered nurses holding additional roles and responsibilities in the organisation. Quality indicator data is collated each month and reported to the organisation`s support office. Analysis of the set clinical indicators and relevant corrective action plans are developed and implemented by the clinical services manager to address any shortfalls. Staff and family satisfaction surveys are completed annually. The last survey was</p>

		<p>completed September 2017 and results were available and had been fed back to staff and families.</p> <p>Policies and procedures 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. Heritage Lifecare Limited has implemented Heritage Lifecare Limited policies and procedures since the previous audit. All are based on good practice and are current. The quality co-ordinator interviewed has introduced 'tool box talk' at handover and during education sessions to discuss any new documents with staff and this is working effectively. The document control system, referencing of relevant sources, approval distribution is organised by the organisation's support office management team. The facility manager and clinical services manager are responsible for the replacement and removal of any obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of any risks and development of mitigation strategies. The facility manager when interviewed was familiar with the Health and Safety at Work Act (2015) and has implemented the necessary requirements.</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 incident form. A sample of incident forms received showed these were fully completed, incidents were investigated, action plans developed and actions followed up and implemented in a timely manner. Adverse event data (hard copy) is collated, analysed and reported electronically in a new system introduced 08 July 2017 (GOSH). Monthly statistics and a narrative report are generated and any trends are identified and reported back to staff.</p> <p>The facility manager described essential notification reporting requirements, including pressure injuries. The national quality manager interviewed maintains a register for any notifications reported to support office. Any correspondence was retained in the register. There have been two Section 31 notifications since the last audit one for a resident admitted with a grade 4 pressure injury and for an infection control outbreak. The change of clinical services manager (August 2017) and the facility manager (04 September 2017) were notified to the Ministry of Health (MoH) as verified.</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>Human resource 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 consistently implemented and records are maintained. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p>

		Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. All staff have completed education for dementia care. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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 if needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of the roster cycle 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 and there is twenty four hour/seven days a week (24/7) registered nurse coverage of the facility at all times.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the signature and designation of the person making the entry identifiable. The service has recently implemented a quality improvement initiative to ensure the staff also print their name on progress note entries, with the service evidencing an improvement in this. 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.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for	FA	The admission policy includes the procedure to be followed when a resident is admitted to the service. The admission agreement contains all required information and is based on an aged care association agreement. Entry screening processes are documented and communicated to the resident and their family/whanau and other health professionals (such as psycho-geriatricians) to ensure the service can meet the needs of the resident. The family/whanau reported the admission agreement was discussed with them prior to admission and all aspects were understood. Needs assessments from various funders

services has been identified.		(eg, DHB, ACC) for either specialist dementia level of care or hospital/psycho-geriatric level of care were sighted in the residents' files sampled.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>All residents' exit, discharge or transfer is documented using specific forms. The service utilises the transfer forms approved by the DHB and this was confirmed in files reviewed. Known risks are identified to the place of transfer to manage the residents safely. Expressed concerns of the resident and family/whānau are clearly documented including advance directives and EPOA documentation. This was confirmed in the resident's files sampled.</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>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management, using an electronic system, was observed on the days of audit. The staff observed demonstrated good knowledge and understood 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>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Two RNs check medications against the prescription when new packs arrive. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</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 reviewed of temperatures for the medicine fridge and the medication room were within the recommended range.</p> <p>The medications are prescribed through the web based system for good electronic prescribing practices, which includes the live update of any changed medications, the date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines are met. The required three-monthly GP review is consistently recorded on the medicine record. There are no standing orders.</p> <p>Self-administration of medications is deemed not appropriate for the resident with cognitive impairment.</p> <p>There is an implemented process for analysis of any medication errors (which includes documenting of omissions), with quality projects and internal audits evidencing the reduction in medication errors since the introduction of the web based medication 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>Policies and procedures implemented cover all aspects of food preparation. Documentation identifies that safe food hygiene management practices are followed.</p> <p>The menu has been reviewed by a registered dietitian as being suitable for the residents living in a long-term care facility. The kitchen has dietary information for all residents and their likes and dislikes are catered for. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The family/whānau reported being overall satisfied with the meals and fluids provided, including catering for their individual preferences. There is food available 24 hours a day.</p> <p>Food, fridge and freezer recordings are undertaken daily and meet requirements. The service has a registered food safety plan and is compliant with the requirements in the plan.</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>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local Needs Assessment and Service Coordination (NASC) is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>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. The clinical manager reported that they refer residents to different levels/types of care if they are unable to support the resident (such as the need for acute mental health support).</p> <p>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>	<p>FA</p>	<p>The initial assessment, which includes assessment of the resident's health and personal care needs, is completed on the day of admission. Registered nurses utilise standardised risk assessment tools for the initial and ongoing assessments, which includes specific assessments for management of challenging behaviours. The interRAI, along with other paper based assessments, information gained from the resident and their family/whānau, referral information, observations and examinations carried out, are used as a basis for developing the long-term lifestyle plan. Family/whānau expressed satisfaction with the support provided and 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>	<p>FA</p>	<p>In all files sampled, evidence was sighted of interventions related to the desired outcomes. Risks identified on admission are included in the lifestyle plan and these included falls risk, pressure area risk and pain management. The assessment outcomes from the interRAI assessment process were included to update the lifestyle plan. The lifestyle plans are discussed with the clinical team at multi-disciplinary meetings. The residents' files sampled recorded that all residents have a behaviour assessment and plans to manage any behaviours that are challenging over a 24 hour period.</p> <p>All health professionals had documented in the resident's individual clinical file and have access to lifestyle plans and progress notes as part of the integrated file system. Documentation in files reviewed included nursing notes, medical reviews and hospital correspondence. The family/whānau reported that they are included in the lifestyle planning and are aware of any changes and these are discussed with them. Care staff reported they are informed of any changes to lifestyle plans at shift changeover. The family/whānau reported satisfaction with the care provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate to the resident's needs.</p> <p>Care staff confirmed that care was provided as outlined in the 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> <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>CI</p>	<p>The activities programme has gained a continuous improvement rating. There is a full range of social activities that are available on the weekly programme for all residents to participate in. The activities provided are individualised to be meaningful for people living with dementia and cognitive impairment.</p> <p>The diversional therapists and activities coordinators plan activities to meet the resident's abilities. This includes the needs of the younger people at the service. Information gained by an activities assessment and resident's history assessment is used when developing the activity plan. There are planned activities that cover physical, social, recreational and emotional needs of the residents. The activities programme is an evolving plan to match weather conditions and resident's abilities and varying levels of cognitive impairment. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events and outings are offered. Residents and families/whānau are involved in evaluating and improving the programme through weekly residents'</p>

		<p>meetings and family/whanau satisfaction surveys.</p> <p>There are activities specific for the younger people living at the service, which include working with other providers for community participation and outings. The family/whānau reported that the activities programme is of interest to the residents and that they are encouraged to visit and maintain links with their relatives living at the service.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluations are conducted at least every six months and recorded on the lifestyle plan. The service has processes in place to use the interRAI re-assessments as part of the evaluation. Care evaluations are conducted for all the residents' needs and record how the resident's goals have been met over the past six months.</p> <p>When there are changes in the resident's needs, the service changes the long-term lifestyle plan to capture these. The long-term lifestyle plans identify the need, interventions and evaluation of the interventions. There are also additional short term plans, such as wound treatment and infection treatment plans, which capture any short-term changes. Wounds are evaluated at each dressing change and at least weekly by the nurses. If the issue then becomes a long-term need, these are then recorded and updated on the long-term lifestyle plan. Any changes to lifestyle plans are reviewed by the nurses and caregivers at handover.</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 to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. 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 radiology, health screening, and medical/surgical specialists. There are several specialists/health providers that also conduct visits to Colwyn House, such as podiatrists and dietitians. 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 the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service</p>	FA	<p>Staff follow documented processes for the management of waste, 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</p>

<p>providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>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>	<p>FA</p>	<p>The current building warrant of fitness expires 28 February 2018. This is publicly displayed in the reception outside the facility manager's office.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and are well maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment is hazard free, residents are safe and independence is promoted at every opportunity.</p> <p>External areas are safely maintained and are appropriate to the resident groups throughout the facility. Pathways sighted have even surfaces. Handrails are provided throughout the facility in all of the three wings. Staff confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment provided for the residents. The dementia unit is designed with access to secure outdoor areas, so that residents can wander freely.</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>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities observed throughout the facility in close proximity to the resident's individual rooms. Only three individual resident's rooms have ensuite bathrooms (Rooms, 3, 9 and 19). Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with photos, pictures and other personal items displayed. There is room for mobility aids, wheelchairs and staff using hoists. Staff have been trained to use hoists and competencies were sighted. Staff reported adequacy of bedrooms.</p>

areas appropriate to the consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Kowhai wing has one smaller lounge which residents can access for privacy or if quietness is required due to the nature of the services provided. Furniture is appropriate to the setting and residents` needs.</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>	FA	<p>Laundry and cleaning services are provided and undertaken on site. There is a designated laundry which is well designed and staff interviewed demonstrated a sound knowledge of the laundry processes. There is a dirty/clean flow identified in the laundry and staff are fully informed of handling soiled linen and provision of managing this aspect of service delivery is clearly understood and is in line with the infection control processes documented for the facility. Family and staff reported that the laundry is managed well and the resident`s individual clothing is returned in a timely manner. The care staff put all clothing away in the residents` own rooms.</p> <p>The linen cupboards are stocked daily and adequate supplies were evidenced. There is a small designated team who provide the cleaning services and all have received appropriate training. Chemicals used for the laundry and cleaning are stored in locked cupboards when not in use. The chemicals in use are stored in appropriately labelled refillable containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and the machinery and chemicals (products) are also monitored by the contracted service provider representatives who visit the facility on a regular basis.</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>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 27 November 2014. A trial evacuation takes place six monthly with a copy sent to the New Zealand, the most recent being on the 28 November 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Emergency lighting has been changed to LED lighting for more effectiveness as a quality improvement. Emergency lighting is regularly checked.</p>

		<p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, head torches and a gas barbeque was sighted to meet the requirements for the number of residents at this facility. Water storage is available in each of the three wings in the facility. There is no emergency power in the form of a generator on site. The service has an arrangement with a local provider for a generator to be provided in an emergency.</p> <p>Call bells alert staff to residents/staff requiring assistance. Call system audits are completed and batteries are checked six monthly.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and re-checked by the night staff. Surveillance cameras are in operation around the facility. Signage is noted and visible in the secure wings. The service is totally environmentally secured due to the nature of the services provided. Swipe card access and pin number access for staff promotes a safe environment for the residents, visitors, staff and families.</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 windows. Gas heating is provided in all wings of the facility. Six monthly checks of all heating units are completed and records were sighted. The lounges/hallways have ceiling heating. Areas were warm and well ventilated throughout the audit and families and staff 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 the size and scope of the service.</p>	FA	<p>There are designated infection control coordinators for the service. They have a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings and the service has commenced an infection control committee structure (from January 2018). The staff meeting minutes sampled included feedback to staff on the monthly quality indicators, risk and infection control issues. The review of the infection control programme (infection control governance) was conducted in April 2017. The programme reviews the effectiveness of the infection control programme, education, surveillance and equipment. The staff meetings sampled evidenced discussion on the outcomes of the review of the infection control programme.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise family/whānau not to visit if they are unwell, especially if there are community outbreaks of infections. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application of infection prevention and control principles.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator implements the infection control programme, with support from all staff. There is also an external contract with a specialist infection prevention and control advisory service to assist in the development of policies. Infection control matters are discussed at the monthly staff meeting. If the infection control coordinators require additional advice or support regarding infection prevention and control they can access this through the DHB or the external advisory service.</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>	FA	<p>The infection control policies and procedures have been developed by the organisation and an external advisory service and reflect current accepted good practice. The service has access to good practice resources from a specialist infection prevention advisory service. The policies are appropriate to the services offered by the facility and reviewed by the national head office.</p> <p>Staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions per the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator and external specialists conducts most of the face to face infection control education. There are learning modules that are part of the orientation and mandatory education programme on infection prevention and control. The staff interviewed demonstrated current knowledge in infection prevention and control. The infection control coordinator has attended ongoing education on current good practice in infection prevention and control and is a member of a local infection control group that have two monthly meetings.</p> <p>As required, infection control education can be conducted informally with residents, such as encouragement of handwashing after personal cares. Information brochures and informal education is provided to family/whānau when there are community outbreaks or requirements of additional transmission based precautions at the facility.</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>The service uses standardised definitions applicable to aged care that are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the aged care service with data collected on urinary tract infections, influenza, skin infections and respiratory tract infections. There is monthly collection and collation of the types and numbers of infections as part of the clinical indicators reporting to head office.</p> <p>The data and reporting of the statistics and analysis is provided to the organisational wide governance/quality team. The outcomes are fed back to the staff at the next staff meeting. The infection surveillance records included the review and analysis of the data. With an increase in the number of respiratory tract infections in December 2017 (this was reflective of community norms at the time), the service implemented actions to reduce the recurrence of spread of the infections.</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 provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. On the day of the audit six residents were using a restraint. Two residents were approved for two forms of restraint, for example, a chair brief and a cot side when in bed. This was fully documented in the restraint register reviewed. No residents were using an enabler due to the nature of this service.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, records reviewed, and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group, made up of the clinical services manager (restraint coordinator), a registered nurse and a general practitioner are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group minutes, residents' records and interviews with the coordinator that there are clear lines of accountability and all restraints have been approved, and the overall use of restraints is being monitored and analysed. Evidence of family/whanau/EPOA involvement in the decision making was on file in each case. Use of restraint is documented as part of the plan of care.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The registered nurse undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whanau/EPOA. The restraint coordinator interviewed described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint is actively minimised and the restraint coordinator described how the alternatives to restraints are discussed with staff and family members, for example the use of sensor mats and low beds. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understand that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' records showed that the individual use of restraints is reviewed and evaluated during the care plan and interRAI reviews, six monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p>	<p>FA</p>	<p>The restraint committee undertakes six monthly review of all restraint use which includes all the requirements of the Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings reviewed confirmed</p>

<p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint education and feedback from the doctor, staff and families. A six monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Date reviewed, minutes and interviews with staff confirmed that the use of restraint has been reduced by four over the last year.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>There is a full range of social activities that are available on the weekly programme for all residents to participate in. The activities programme has been reviewed and changes implemented since May 2017. The recommendations for the changes to the programme are documented and reported to senior management and the head office. Residents who have dementia and other diagnosis of cognitive impairment are assessed for their level of ability, and specific strengths and abilities which are used to facilitate meaningful activities for the individual residents. The resident's activities plan sampled evidenced documented evaluations on the resident's participation and the outcomes that residents are achieving from these. With the evaluation of the changes to the activities programme, the service has implemented further meaningful activities for residents. The service provides a documented evaluation and implemented weekly meeting with the residents where feedback about activities is gained and changes to the programme are made as indicated. Since the implementation of the changes to the activities programme, there has been a decrease in the recorded amount of challenging behaviours and an increase in overall wellbeing of the residents and</p>	<p>The achievement of the quality improvement projects in activities programmes and implementation of the changes is rated beyond the expected full attainment. With these projects and review of the activities programme there has been a documented review process which includes the analysis and reporting of findings. The introduction of the new activities programme, including the changes of times of the day that the activities are provided, and the evaluation of the previous programme include documenting actions to make improvements in the activities programme. With this implementation, there has been increased development and increasing resident's skills and participation in</p>

		<p>participation in activities (evidenced from resident and family/whānau feedback and photographic comparisons). The family/whānau interviewed reported that they have seen an increase in meaningful activities in the last six months and report that this is a strength of the service.</p>	<p>meaningful activities. Positive outcomes have been measured in staff, resident and relative satisfaction. The documented outcomes include a decrease in challenging behaviours and an increase in resident's wellbeing.</p>
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End of the report.