

Heritage Lifecare Limited - Dunblane Lifecare

Introduction

This report records the results of a Provisional 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:	Dunblane Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 30 July 2018 End date: 31 July 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:	56

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

Dunblane Rest Home (Dunblane Lifecare) can provide rest home, dementia and hospital level care for up to 75 residents. The facility is operated by Oceania and managed by a business and care manager working closely with a clinical manager. Both these managers are new to their roles since the last audit in February 2017. Residents and families spoke positively about the care provided.

This provisional audit was conducted against the Health and Disability Service Standards and the facility's contract with the district health board. The audit process included an interview with a representative from the prospective provider, review of policies and procedures, review of staff and residents' files, onsite observations and interviews with family members, staff, local and regional management, a volunteer and a general practitioner.

The audit has resulted in a continuous improvement rating in recognition and support for Māori cultural values. Four identified areas requiring improvements related to the lack of spiritual, cultural and activity related goals and information in resident's files; inadequacy of the content in service delivery plans which were non-individualised; inconsistencies with the dates of some resident related documentation and call bell issues.

This facility is one of several being purchased at this time by Heritage Lifecare Limited (HLL) following the purchases of 16 other facilities since late 2017. HLL is a national provider with senior staff experienced in rest home, hospital and dementia level services. The HLL National Manager Clinical and Quality reported in June 2018 that HLL have a senior project team managing the transition of each new facility to HLL processes over a period of six months. The Dunblane management have been informed of the purchase

date and the transition plans by HLL management. The transition will include the changeover to HLL, infrastructure support, policies, procedures and processes, and information technology systems. Workshops will be held for Dunblane staff as part of the transition plan.

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 family members receive a copy of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) brochure on admission and copies of the poster are on display. Opportunities to discuss the meaning of the Code, consent, how to make a complaint and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Resident who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal and informal interpreting services if required.

The service has strong linkages with a range of specialist health care providers, especially Aged Concern. Such links contribute to ensuring services provided to residents are of an appropriate standard. Advocacy services have been accessed when required.

Complaints are managed in line with the requirements of the Code of Health and Disability Services Consumers' Rights.

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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Dunblane Lifecare reflects the person-centred scope, direction, goals, values and mission statement of the Oceania organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

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 supports safe service delivery and includes regular individual performance review.

Residents' information is securely stored and not accessible to unauthorised people. Records were legible and maintained in individual hard copy files.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The local Needs Assessment and Service Co-ordination Service liaises with the service provider to ensure access to the facility is appropriate and efficiently managed. Sufficient and relevant information is provided to prospective residents and their family to facilitate the admission process.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff, designated general practitioners and a nurse practitioner from a local GP practice. Shift handovers and communication sheets guide continuity of care.

Care plans are based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. There are defined processes in place for the identification and review of residents' needs, goals and outcomes to occur on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

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

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by both registered nurses and health care assistants, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with the meals.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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 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.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. There are fire sprinklers throughout the facility. Fire evacuation procedures are regularly practised. 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 the minimisation of restraint. Two enablers and four restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. 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 appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee. Specialist input is available both at local and national levels from the public health unit in the local district health board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies. Infection prevention and control is included in staff orientation and regular education sessions.

Aged care specific infection surveillance is undertaken. Related data is analysed, examined for trends and benchmarked with other similar facilities. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	46	0	2	2	0	0
Criteria	1	96	0	2	2	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>Dunblane Lifecare 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 interviewed 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 process for all staff employed and is a component of the annual study days for registered nurses and the 'Grow, Educate, Motivate' (GEM) annual study days that all healthcare assistants complete. This was verified in the information on GEM and in staff training records.</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>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff.</p> <p>Person centred care plans reviewed showed that informed consent for care and support has been gained appropriately using the organisation's standard consent form including for photographs. A</p>

		<p>separate consent form for outings and another for influenza vaccinations were viewed in residents' files.</p> <p>Copies of signed advance directives, and copies of enduring power of attorney (EPOA) documentation were sighted. All except one resident in the dementia service have had an EPOA activated. The clinical and quality manager and the clinical manager described actions currently underway by the family to address the exception. Processes for residents unable to consent are defined and documented where relevant in the resident's record. The senior nurses demonstrated their understanding by explaining situations when this may occur. Medical input is being obtained to confirm the competency of some residents giving consent, or to sign off on documentation that guides staff in the event of an adverse event for people who do not have an advance directive.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis and this was confirmed during interviews with residents and family members.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception.</p> <p>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>Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed with the coordinator for quality management. An independent advocate had been used when a person's condition changed, and another example provided was the use of Aged Concern to manage a challenging situation. A third example in relation to a decline of entry was also discussed.</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</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 has strong family and community links</p>

<p>and their community.</p>		<p>overall, which staff described was a point of difference within this service.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they feel welcome when they visit and comfortable in their dealings with staff. There are connections with other local rest homes, local churches and various community groups, many of which have a Māori cultural base. The children from a school and a kindergarten visit regularly.</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 those interviewed knew how to do so. Copies of the Code and advocacy services brochures were available at reception.</p> <p>The up to date complaints register reviewed showed that seven complaints have been received so far this year 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.</p> <p>The Business and Care Manager (BCM) is responsible for complaints management and follow up. The Clinical Manager works with the BCM as required to investigate complaints of a clinical nature.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been three Health and Disability Commissioner (HDC) complaints received since the previous audit and there are three historic open HDC complaints which have been responded to, with the facility continuing to wait for a response from the HDC.</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 interviewed knew about the Code and family members confirmed they had been informed about them. Copies of brochures on the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) are provided by the business and care manager within the admission packages, of which an example was sighted. The Code is displayed in frames in all areas of the facility together with information brochures on the Code and advocacy services, how to</p>

		<p>make a complaint and copies of feedback forms. The clinical manager advised that she is the person responsible for discussing these topics with residents and families when a new person is admitted.</p> <p>The prospective provider already manages a chain of rest homes. Their policies and procedures have a strong focus on consumer rights and one of the prospective managers confirmed their knowledge on consumer rights.</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>A notice near the facility entrance advises that the privacy officer is the business and care manager. Residents and families confirmed that they are receiving services in a manner that has regard for their dignity, privacy and personal choices. The clinical manager explained that residents and family members are advised about and given options in regard to the storage of personal items of greater value.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares and when exchanging verbal information. All current residents have their own private room.</p> <p>Residents are encouraged to maintain their independence by being assisted with mobility aids and making their own decisions about what they will participate in. Each care plan sighted included documentation related to the resident's abilities, and strategies to retain the independence they have.</p> <p>Records reviewed in care plans confirmed that each person has been asked about their individual cultural, religious and social needs; however as identified in 1.3.4.2 the assessment process lacks adequacy in this area as the goals related to cultural and spiritual interests are non-definitive. Ministers and pastors from four different denominations of churches take turns at providing services at the facility, which are provided weekly. Communion is available. A chaplain undertaking the practicum for chaplaincy training visits weekly and there is a possibility this will become a permanent role.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. An example of an abuse situation having occurred was reported as was the subsequent consequences. Documentation in relation to this was verified in the reports. Education</p>

		on abuse and neglect is part of the orientation and the annual GEM training programme for staff.
<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>A Māori Health plan policy includes relevant cultural definitions, an overview of the principles of the Treaty of Waitangi, guidelines in relation to Te Whare Tapa Wha, the four cornerstones of Māori health and a section on staff education is included.</p> <p>Approximately a third of residents in this facility identify as being of Māori descent. Staff support these residents to integrate their cultural values and beliefs. Family/whānau are encouraged to be involved as their importance is recognised. Current access to resources includes the contact details of local cultural advisers with whom the diversional therapists, in particular, have strong links. Local Māori people are welcomed into the facility to play chess, board games and the ukulele and to provide entertainment for the residents. Strong links are being maintained with the Poho-o-rawiri marae. One of the Māori entertainers assists with blessing rooms when residents die.</p> <p>Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. An example of this is that residents in the dementia service who choose to speak te reo at times have this acknowledged by staff who are competent in responding accordingly. Māori residents and their whānau who were interviewed reported that staff acknowledge and respect their individual cultural needs and expressed appreciation for the number of Māori healthcare workers.</p> <p>A rating of continuous improvement has been allocated for the manner in which whānau are recognised and supported by the staff, as was evidenced from verbal reports and in an album of photographs and summaries of two specific projects.</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>Person centred care plans include a section for recording information about individual culture, values and beliefs. These were completed, albeit with generalised statements and generic goals (as identified in the corrective action for 1.3.5.2). Where people identify as Māori, this was noted. Staff demonstrated respect for the residents and were observed asking about and honouring personal preferences. For example, a person who had not been out of her room for a lengthy time was supported to join others and their comfort was monitored;</p>

		<p>another's person refused to participate in an activity and this was respected; and in another instance, staff went to all lengths to ensure a person with severe disabilities was appropriately positioned and all comfort measure instituted. Although brief, special needs were referred to in person centred care plans reviewed. Family members expressed satisfaction with the level at which cultural needs are met and references were made to the projects as described in criterion 1.1.4.5.</p> <p>The importance of music for some is recognised, as is the importance of reading matter with a collection of library books from the local library changed once a month.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The nurse practitioner expressed an overall satisfaction with the standard of services provided to residents.</p> <p>A staff Code of Conduct is in place and all staff are provided with a copy of this when they commence. There is further clarification in the employment agreements. Staff are required to sign they have read and understood the Code of Conduct and this was verified in the signed copies in staff files reviewed.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours and this was also evident in staff orientation records reviewed. Ongoing education is provided on an annual basis, which was confirmed in the annual GEM training documentation and in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence based policies and procedures that include documented references were in place. Input from external specialist services and allied health professionals is sought, for example, a diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians and mental health services for older people. The nurse practitioner advised that staff will access further professional advice when indicated</p>

		<p>and that treatment orders are followed through.</p> <p>Staff reported they receive management support for external education and access their own professional networks, including outside of Gisborne, to support contemporary good practice. An example of this was that the healthcare assistant who is also the manual handling specialist is about to go to Auckland for a specialised training course.</p> <p>Another example of good practice observed during the audit included the use of the strong family orientations among the residents, their family/whānau, the staff and the wider local community members. There is a strong sense of community within this service, especially among those who identify as Māori. There were multiple examples of community integration, social support and 'aroha' described and reported.</p> <p>The clinical manager and the clinical quality manager both commented on the value of the GEM study programme and the long service of so many staff, which enables them to know the needs of residents and their family well and increases their ability to work autonomously.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<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 the family communication record in residents' records reviewed and in copies of incident reports filed in residents' records, which have a tick box to confirm this has occurred. There was also evidence of resident/family input into the care planning process and the follow up evaluation. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the district health board, the needs assessment and coordination service and Aged Concern when required. Staff knew how to do so, although reported this was rarely required due to residents generally being able to speak English. An example of a resident's family member being used for a period of time was given with staff using other strategies when that person was absent. Staff demonstrated patience when assisting residents with</p>

		<p>speech impediments. Hearing aids are being put in for those who need them and there were examples of residents attending audiology clinic appointments.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The organisation's mission and values are clearly displayed on the wall at reception and throughout advertising material. The philosophy and strategic plan reflect a person-centred approach to services as does staff practice observed.</p> <p>The facility's operational and quality data is collated into a national report. A sample of monthly reports showed adequate information to monitor performance is reported including financial performance, clinical incidents and health and safety key performance indicators. These comprehensive monthly statistical reports are collated at the support office and benchmarked reports are provided to the business and care manager (BCM) and clinical manager.</p> <p>The service is managed by a Business and Care Manager (BCM) who holds relevant business qualifications and has been in the role for nine months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The BCM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through relevant sector training. The regional clinical quality manager provides regular onsite and offsite feedback and support.</p> <p>The service holds contracts with the local DHB for Rest Home, Dementia level, and Hospital level care, ACC and MOH for young persons with physical disability (YPD). In total, twenty six-residents were receiving hospital level care, 19 rest home care and 11 residents were receiving dementia services. One of these people was receiving Accident Compensation Corporation (ACC) funding and another person was on a YPD contract, the remaining 54 people were under the ARRC contract at the time of audit. The facility has 75 beds including the rest home level Orchid Wing which is currently unoccupied and closed.</p> <p>New Provider Interview July 2018:</p> <p>The new provider is Heritage Lifecare Limited (HLL), an established New Zealand aged care provider, operating more than 2042 beds in the sector. The acquisition of Dunblane is part of the next round of</p>

		<p>purchases currently underway which will add several more facilities across the country to HLL group. The National Manager Clinical and Quality reported (July 2018) that the same process used towards the end of 2017 for a series of acquisitions will be used for the purchase of the Dunblane facility and others.</p> <p>An organisational structure document sighted details the reporting lines to the board in place as at 30 November 2017.</p> <p>The transition plan which was commenced in late 2017 is led by an experienced and well-qualified project team who are specifically focussing on the integration of the current facilities into the HLL group. This includes provision of infrastructure support such as providing information technology capability including hardware and software. The workshops to introduce documentation, and the new HLL systems and processes have already commenced for newly purchased facilities and are planned for Dunblane and the other facilities being purchased at this time. The HLL project team plan to work with the Dunblane management team to ensure a smooth transition within the first three months.</p> <p>It is expected that the senior team will remain in place at each facility and that existing staff will transfer to the new provider. HHL has notified the relevant District Health Board prior to the provisional audit being undertaken.</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 BCM is absent, the clinical manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the regional clinical quality manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p> <p>New Provider Interview July 2018:</p> <p>The prospective provider is not planning any staffing changes. Existing cover arrangements for the day to day operations will remain in place, with access to regional operations managers. The prospective new owner understands the needs of the different certified service types and understands the Age Residential Related Care (ARRC) agreement, including in relation to responsibilities of the ARRC</p>

		manager to meet section D17 of the agreement.
<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>	FA	<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 patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and pressure injuries.</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, quality improvement meetings, specific team meetings, restraint meetings, health and safety meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and meeting attendance. Relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent resident survey in April 2018 showed 100 percent satisfaction. Residents' feedback is also obtained through the regular residents' meetings.</p> <p>Policies are managed by the Oceania support office, are based on best practice and were 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 BCM described the processes for the identification, monitoring, review and reporting of hazards, risks and development of mitigation strategies. The BCM is undertaking the Oceania's managers step up programme and is supported by the regional clinical quality manager to ensure risks are managed and mitigated. The support office has incorporated the changes from the Health and Safety at Work Act (2015) into health and safety processes. These are managed through the local health and safety committee and reported on.</p> <p>New Provider Interview July 2018:</p> <p>During the transition phase, HLL policies and procedures will be introduced. The National Manager Clinical and Quality anticipates, a new software system will be introduced to incorporate risk</p>

		<p>management including adverse event reporting, care planning and client management, within six months of the purchase.</p> <p>HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure. Dunblane clinical staff will be included in the new HLL national clinical governance group, the introduction of which is a key HLL strategy for 2018.</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>Dunblane staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, near miss events are documented regularly, incidents were investigated, corrective action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed, reported and benchmarked within league tables via the national Oceania electronic system.</p> <p>The BCM described essential notification reporting requirements, including for pressure injuries, which is done by the Oceania general manager clinical quality. They advised there has been 13 notifications of significant events made to the Ministry of Health, Police or the district health board in the 17 months since the previous audit. These included a resident absconding, and an infectious outbreak.</p> <p>New Provider Interview July 2018:</p> <p>There are no known legislative or compliance issues impacting on the service. The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. The HLL national manager clinical and quality interviewed was able to verbalise knowledge and understanding of actions to meet legislative and DHB contractual requirements.</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</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process is managed within an electronic system and includes referee</p>

<p>requirements of legislation.</p>		<p>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.</p> <p>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 comprehensive documentation of completed orientation and a performance review after a three-month period.</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. An Oceania staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. 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.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is an Oceania documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Dunblane managers state the Oceania matrix is based on full occupancy and that they adjust staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Managers reported they use casual staff as agency staff are not available to cover gaps in the roster. Care staff reported there were usually adequate staff available to complete the work allocated to them although at times with an immediate increase in acuity they felt unable to provide their usual level of care, however rosters reviewed showed a full complement of staff, as defined in the Oceania documented requirements. Residents and family interviewed supported this. No evidence of support to residents being compromised was evident from incident reports on the days of audit. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any</p>

		<p>unplanned absence. At least one staff member on duty, but usually more, has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage in the hospital.</p> <p>New Provider Interview July 2018:</p> <p>The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL interviewed was confirmed understanding of the required skill mix to ensure rest home, hospital and dementia care residents needs are met. The organisation already provides the full range of levels of care (hospital - geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services.</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>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully 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 being entered into the Momentum electronic database.</p> <p>Written residents' records were legible, although the designation of the person making the entry was not always identifiable. This has been included in a corrective action relating to the need for all types of resident related information, especially different types of review documentation, to be completed in a timely manner.</p> <p>Archived records are held securely on site in downstairs cupboards for current residents and are readily retrievable using a cataloguing system. Archived records for people who are no longer in residence are stored upstairs in the attic. Residents' files are held for the required period before being destroyed.</p> <p>One example of a cupboard of residents' files being unlocked was found. During the audit, four more checks were made in each of the three areas where residents' information is stored. No further examples of personal and private resident information being accessible to the</p>

		public were evident during the audit.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>An information package is made available to prospective residents and their family/whānau on enquiry. Prior to entry, residents are required to have their level of care assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families/whānau are encouraged to visit the facility prior to admission and meet with the business and care manager who provides additional written information about the service and the admission process. There is not currently a waiting list as there are empty beds in all service areas. The clinical manager is also involved in the introductory/entry phase. Although staff informed it is not always easy to get dementia specialist support in this district, referrals to the dementia service demonstrated appropriate referral and admission processes had occurred for the people whose files were reviewed.</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 demographic detail and copies of assessments. Signed admission agreements are in accordance with contractual requirements and held securely within the administration/reception area. Those for residents in the dementia service confirmed the involvement of the enduring power of attorney.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner. Family members are encouraged to be involved when possible and appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. To facilitate the transition, a completed transfer form, any advance directive and medicine records are copied or printed of and provided. There was evidence of open communication between all services, the resident and the family. All referrals are documented in the progress notes and these were clear both for the transfer out process and for the transfer back in. These processes were evident in three sets of residents' records for people who had been into the local public hospital.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy 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, using an electronic system, was observed on the day of audit. The staff observed administering medicines on both days of the audit demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management they were responsible for. According to a spreadsheet sighted, 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. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks, including by the pharmacy, and accurate entries.</p> <p>Review of the records of temperatures for the medicine fridge confirmed they were within the recommended range.</p> <p>Prescribing practices, recording of dates for the commencement and discontinuation of medicines, notation of allergy status and all requirements for pro re nata (PRN) medicines were consistent with the requirements of the electronic system in use. All records sighted demonstrated that medicine requirements had been reviewed within the last three months by either a general practitioner, or a nurse practitioner.</p> <p>There was one resident who self-administers an inhaler only and one who self-administers a nasal spray. Both had current competencies on file. Appropriate processes are in place to ensure these are managed safely.</p> <p>Medication errors are reported to a registered nurse and the clinical manager and are recorded on an accident/incident form. The national</p>
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<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 a qualified cook and kitchen team. The four-week rotating menu follows summer and winter patterns. Records of a dietitian having reviewed and approved the current winter menu, confirming the meals on the menu are in line with recognised nutritional guidelines for older people, were sighted.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any personal food preferences, special diets and modified texture requirements are made known to kitchen staff who sign they are aware of them. The individual requirements are being accommodated in the daily meal plan. Monthly weights of residents are recorded and monitored with follow-ups undertaken when there is evidence of significant or ongoing weight loss. There is a fridge and pantry cupboard accessible to the residents and staff in the secure unit, which ensures they have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet individual resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified during resident and family interviews. Residents were observed to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. Family members were also assisting during meal times.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines and kitchen cleaning schedules are being upheld. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries with an expiry date of 28 March 2019. Food temperatures, including for high risk items, are</p>

		<p>monitored appropriately and recorded as part of the plan, as are fridge and freezer temperatures and the temperatures of chilled food on entry to the facility. Foods are being stored safely with leftovers discarded the following day and sandwich fillings within 48 hours. The main cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services 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 the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. 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 in consultation with the resident and whānau/family, a new placement found.</p> <p>An example of a person not meeting the criteria was discussed. The service provider worked with NASC and an advocate to find a more suitable place for one person who was admitted but was then found not to meet the criteria. There is a clause in the access agreement related to when a resident's placement can be terminated, and the process was followed.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>Information is documented using validated nursing assessment tools such as an initial nursing care plan and a range of others including a formal nutritional assessment, the Abbey pain scale, a continence assessment and any others that may be required, such as behaviour or skin integrity, for example, according to the triggers from the interRAI outcomes. These tools are being used to identify any deficits and to contribute to development of the person-centred care plan. There were gaps in completion of the personal profile 'About Me', which is intended to facilitate development of the sections of the care plans in relation to residents' activities, including meeting cultural and spiritual needs.</p> <p>The sample of care plans reviewed had an integrated range of resident-related information, including from external sources, from the GP and nurse practitioner reviews. There was however examples of residents' files that had not had a GP admission review completed within the required timeframe. All residents have current interRAI assessments completed by one of the trained interRAI assessors on</p>

		site, or the clinical and quality manager from Oceania, Auckland.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Triggers, outcomes and assessment summaries as identified by the interRAI assessments are reflected in all of the person-centred care plans reviewed. Plans reviewed reflected the outcomes of the integrated assessment process, support needs of residents, and other relevant clinical information. However not all person-centred care plans were individualised or described the required interventions in the level of detail required for a staff person to be able to provide adequate service delivery. The documentation associated with the 24 hour activity planning wheels in the files of residents in the dementia service included guidance for the identification and management of restlessness and adverse behaviours.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations documented. 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 care plans.</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 information in the person-centred care plan. The attention to meeting a diverse range of resident's individualised needs was evident during observation of various aspects of service provision. All residents looked tidy, well-positioned and comfortable throughout the audit. Care staff confirmed that care is provided as outlined in the documentation and according to comprehensive handovers from senior staff. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p> <p>Healthcare assistants demonstrated they knew the residents well and paid attention to detail. Those interviewed confirmed they had got to know the residents, their family/whānau and their personal preferences as a result of working at the facility over a number of years. Family members confirmed during interview that they knew some of the staff because they had been working in the facility for a long time and they have links with one another within the local community. All spoken with were full of praise for the staff and what they do, although at least three</p>

		felt they could do with more staff as they get busy. (Refer comments in 1.2.8)
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is led by a full time trained diversional therapist holding the social services certificate in health and wellbeing, social and community services community facilitation, the Diversional Therapy strand. An activities coordinator works 30 hours a week and primarily works within the rest home and hospital areas; whereas the diversional therapist primarily covers the dementia service as well as the retirement village residents. Volunteers assist at designated times of the week and two of these people attended during the audit.</p> <p>On admission, the 'About Me' personal profile that is mentioned in the corrective action for 1.3.4.2, is completed by a registered nurse who develops the activities section of the person-centred care plan. There is minimal information being obtained for the social assessment and history, other than what is obtained from the interRAI, therefore individualised activity plans in the residents' care plans lack direction in some areas. (Refer corrective action in criterion 1.3.5.2.)</p> <p>The diversional therapist develops an activity schedule each week and copies of recent schedules were viewed. These show a diverse range of activities that cover a holistic spectrum for cognitive, physical, mental and social stimulation are being provided. Both of the activities staff are responsible for monthly reviews of participation levels and personal responses to the activities. These are being consistently recorded in all residents' records sighted. Six monthly reviews are completed by registered nurses. The activities staff provide input into the multidisciplinary review documentation prior to the multidisciplinary review meeting.</p> <p>Residents interviewed stated there is always something happening and talked about the things they especially enjoy. One person who prefers their own company expressed appreciation that they are not forced to attend what they are not interested in. Family members informed there was always something going on and a relative of a resident in the dementia service commented on the fact that when staff are busy they may put something in front of a person to fiddle with, or look at and this was observed,</p>

		<p>Activities for residents from the secure dementia unit 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 and this was evident in a 24-hour activity wheel in each resident's record reviewed. These plans are individualised and provide staff with direction to occupy, or distract, or re-orientate a person as appropriate. The diversional therapist described activities that have specifically addressed cultural needs and these programmes have been rated as continuous improvement level in criterion 1.1.4.5 of this report.</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>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the registered nurse and the clinical manager.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. A registered nurse informed that only essential parts of interRAI are followed up at the six-month review time but it is fully reviewed every 12 months. Evaluations are documented by the registered nurses. Where progress is different from expected, or significant changes have occurred, the clinical manager informed that the service responds by initiating changes to the plan of care. All except two of the files reviewed had a brand-new care plan and it was difficult to ascertain what changes had occurred since the previous version as they had been archived.</p> <p>There was however evidence of completed multidisciplinary reviews having been completed within the last few months. These included records of feedback from both family members as well as from a cross-section of staff involved in the particular resident's care. The care plans reviewed reflected the residents' needs as identified in the interRAI outcomes and summaries. Family members or the residents had signed off the updated care plans following the review processes.</p> <p>Examples of short term care plans sighted showed these had been consistently reviewed with updates as relevant and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting</p>

		changes.
<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 when relevant. Although the service has a 'house doctor', residents may choose to use another medical practitioner, or medical practice, and there were examples of this evident in residents' records reviewed. A nurse practitioner is actively involved with the residents in this facility and due to availability, this person was interviewed and provided the information required, rather than a GP. Residents are actively followed up on a regular basis by the nurse practitioner or the GP.</p> <p>If the need for other non-urgent services are indicated or requested, the GP or nurse practitioner, sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to a dietitian, podiatrist, physiotherapy and an ophthalmologist. It was reported that previous letters from specialists that were no longer actively involved had been archived. Residents and family members interviewed confirmed they are kept informed of any problem arising and of referral process, as verified by documentation. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. Records of three such events were reviewed in residents' files where handover information was clear and appropriate follow-up occurred.</p> <p>Support organisations, including Aged Concern, have been accessed for residents at times and examples of these were discussed during the audit.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	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 described and were observed using this appropriately.</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>A current building warrant of fitness (dated 28.11.17) is 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 was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free, residents were safe and independence is promoted, including the ability for dementia wing residents to have purposeful walking when staff are in attendance.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Staff and relatives 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.</p> <p>New Provider Interview July 2018:</p> <p>HLL has undertaken a period of due diligence, including building reports, in preparation for purchase of each facility. There are presently no plans for any environmental changes in the facilities.</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 throughout the facility, situated close to residents' rooms. This includes shared separate toilets and showers. 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 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. All bedrooms provide single accommodation and there is a variation in size. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff, family 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. The dining and lounge areas are spacious and enable easy access for residents, family and staff. Residents can access areas for privacy, if required. 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>	<p>FA</p>	<p>There are guidelines for appropriate use of chemicals and cleaning solutions. These include information about how to handle these products and directions to use material data safety sheets from the product provider and use of appropriate protective equipment and clothing. Training is provided to all staff annually on the use of chemicals and to care and laundry staff on laundry protocols/systems.</p> <p>Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty to clean flow, handling of soiled linen and use of appropriate protective equipment and clothing. Family interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers in the cupboard and on the cleaning trolley.</p> <p>Cleaning and laundry processes are monitored through onsite management review and the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Moderate</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff, including the need to consider the special needs of people with dementia in an emergency. Disaster and civil defence planning guides direct Dunblane Lifecare staff in their preparation for disasters and described 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 29th August 2005. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 16 May 2018. Issues identified with the trials are rectified as required. The orientation programme includes fire and security training. Staff</p>

		<p>confirmed their awareness of the emergency procedures. A recent externally contracted fire sprinkler system survey report refers to 'significant defects' which the BCM states are related to the reception area only, not resident areas and these are being addressed by the regional maintenance manager as evidenced by email communication sighted.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas BBQ were sighted and meet the requirements for the 56 residents. There is a large water storage tank in the garden, and a generator has been provided in the past as required by the local Civil Defence or the national support office. Emergency lighting is regularly tested, and changes made as required.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.</p> <p>Issues have been identified with the call bell system which necessitate staff climbing the stairs to an attic, off an unused corridor, to reset the system. This reset button is at a distance from the hospital wing which is problematic for the night staff. On the day of audit, the call bells were indicating help was required in a toilet; however, this was not the case and the system needed to be reset to stop the audible alarm. Call system audits are completed on a regular basis and the issue had been identified by Dunblane staff as requiring rectification.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. Access to the outside garden and courtyards is through doors off the lounges and communal spaces. Heating is provided by hot water radiators in residents' rooms and in the communal areas. 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</p>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme.</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>Infection control management is guided by a current infection control manual that has been developed at the wider Oceania organisational level. The outcomes of the implementation of the infection control programme are reviewed annually.</p> <p>A registered nurse is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Although this person was unavailable on the day of audit, the clinical manager who oversees the programme discussed the infection prevention and control programme. An infection control committee at the Dunblane Lifecare has five members with management, nursing, and household representation. Infection control matters, including surveillance results, are reported monthly to the clinical manager, who passes them on to the clinical and quality manager and the wider quality management team of Oceania.</p> <p>When there are more than two incidents that might be indicative of an infection within the facility, the infection control coordinator places a sign at the main entrance to the facility advising visitors of the possibility of an outbreak. Through the GEM staff training system, staff are taught about the importance of preventing the spread of an infection, ensuring they are clear of symptoms for more than 48 hours following a gastro-intestinal infection and requesting anyone who is, or has been unwell in the past 48 hours, not to enter the facility. Staff interviewed understood these related responsibilities and also confirmed people are sent home if they are coughing and sneezing.</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>Documents sighted showed that the infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role, after completing a relevant training package in 2016 and maintaining attendance at ongoing study sessions. The service provider has established links with the local District Health Board public health unit and seeks expert advice from the local GP clinics for additional support/information when required. Registered nurses and the infection prevention and control coordinator have access to residents' records and diagnostic results from the laboratory to ensure timely treatment and resolution of any infections.</p> <p>The Oceania clinical and quality manager confirmed that appropriate resources including education, chemicals and personal protective</p>

		equipment, for example, are readily available to support the programme and any outbreak of an infection.
<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>Oceania's infection prevention and control policies (2017-2019) reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies 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, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices and confirmed they are required to read these and learn about them during orientation.</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>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions, especially within the GEM health care assistant training programme.</p> <p>Staff education is provided by the clinical manager and the infection control coordinator at Dunblane Lifecare. Content of the training is documented, and a record of attendance is maintained. There was evidence that additional staff education had been provided following a norovirus outbreak April 2017.</p> <p>Registered nurses advised that education with residents to help prevent the spread of infections is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and covering their nose and mouth while coughing and sneezing in public spaces.</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>	FA	<p>Infection surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, the nurses implement</p>

		<p>relevant treatment and infection control processes. The infection control coordinator ensures each is recorded into an Oceania infection incidence log, which notes which facility, whether it meets the definition, the symptoms, date they began, the laboratory result, treatment, outcome and the date of resolution. In addition, the clinical manager enters the information into the clinical indicators national record, in which data analysis is undertaken, including for infections.</p> <p>The national clinical and quality manager infection control coordinator reviews all reported infections and works through these with the clinical manager to further identify any trends, including benchmarking at the wider organisational level. There are six monthly reviews of the incidence of infections to assess whether there are any opportunities for quality improvement.</p> <p>According to a registered nurse and the clinical manager, and handover records sighted, any new infection is discussed at handover, when staff are reminded of relevant prevention and control procedures. Staff education is implemented when indicated by infection incidence. Surveillance results are shared with staff at their respective meetings, as documented in the meeting minutes. A summary report was sighted for the gastrointestinal infection outbreak early 2017.</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.</p> <p>On the day of audit, four residents were using restraints in the hospital and two residents were using enablers in the rest home, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</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, files reviewed, and from interviews with staff.</p>

		<p>New Provider Interview July 2018:</p> <p>HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for use of enablers. These policies are implemented across the group and a small number of restraint devices are approved for use following assessment. The prospective provider is experienced in the requirements of the standard, as it pertains to aged residential care and dementia care.</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>	FA	<p>The national restraint approval group, made up of the five clinical quality managers and their manager, are responsible for the approval of the overall Oceania use of restraints. The Dunblane restraint group are responsible for the approval of restraints and the restraint processes at Dunblane. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>The cultural safety policy refers to incorporating a resident's culture, values and beliefs into the restraint assessment process. The documentation completed by family/ whānau for residents with restraints in place indicated the residents did not have specific cultural needs in this regard.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint is 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>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the clinical manager/restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The restraint coordinator 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 the four residents who</p>

		were using a restraint.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The use of restraints is actively minimised and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example the use of sensor mats, and low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring were up to date and 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 by the restraint coordinator, 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 Oceania's policy and procedures and in related topics, such as dementia, depression and delirium and positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint was 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>	FA	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, regular 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>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The Oceania national restraint committee undertakes an annual review and the Dunblane restraint group do a two-monthly review of all restraint use which includes all the requirements of this Standard. Two monthly Dunblane restraint meetings and reports are completed, and individual use of restraint use is reported to the regional clinical quality meeting and staff meetings. Minutes of meetings reviewed confirmed this includes analysis and evaluation of the amount and type of</p>

		<p>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 / enabler education and feedback from the doctor, staff and families. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the regional clinical quality manager, clinical manager in her role as restraint coordinator and staff confirmed that restraint minimisation has been actively encouraged. Dunblane is benchmarked with other facilities and restraint has reduced nationally by 70% over the past six years.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.9.1</p> <p>Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.</p>	PA Low	<p>All sections of residents’ person-centred care plans have been updated. There were however inconsistencies in dates between interRAI outcome reviews and multidisciplinary review documents in a number of clients’ records. Other discrepancies included significant variations of up to four months between dates on family feedback and those on the allied health feedback in multidisciplinary review documentation.</p> <p>Multiple variations of staff not noting their designation in resident records were found in various records including progress notes, multidisciplinary review forms and monitoring records, as examples.</p>	<p>There are discrepancies in the dates of different types of resident review records and staff are not always noting their designation on entries in residents’ progress notes, multi-disciplinary review forms and monitoring records for example.</p>	<p>Resident related information is entered into person centred care plans within the expected times, demonstrates service coordination and meets best practice guidelines. All areas of residents’ records shall include the designation of the author.</p> <p>180 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs,</p>	PA Low	<p>Various assessment tools, including interRAI are being used for assessment</p>	<p>The ‘About Me’ personal profiles used for assessment of activity,</p>	<p>All aspects of the assessment processes are sufficiently</p>

<p>outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>		<p>and reassessment purposes. A document called 'About Me' is being used to develop a personal profile and to supplement the information from interRAI and contribute towards the activity, spiritual and cultural assessments and subsequent goals for the care plan.</p> <p>The 'About Me' profiles have several sections and a tick box section of preferences on the reverse had mostly been completed. An information gathering section about whom the person is, their family, what they have done and where they have been for example was blank, or only sparsely completed in many of the person-centred care plans reviewed. Some had a note that families wanted to keep family information private and some noted they identified with a certain ethnicity or pursued spiritual followings but contained no details to guide the person developing the care plan. There was also no evidence of updates to this assessment document as staff gained more information about the person(s) over time.</p> <p>There was an example of a GP admission review not having occurred despite a person being admitted over 28 days ago and the person having an interim visit to hospital. Four other records showed the initial GP visit occurred significantly later than the admission. These delays have the potential to contribute to a gap in medical information for assessment purposes.</p>	<p>spiritual and cultural related information are blank in some cases or lack substantive information causing activity related goals and those related to cultural and spiritual interests to be non-definitive. Admission reviews by a GP are not all being completed within the required timeframe to ensure medical information is up to date.</p>	<p>comprehensive to enable the person-centred care plans to be individualised and prepared in a manner that will enhance the person's lifestyle.</p> <p>180 days</p>
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<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>All of the person-centred care plans that were reviewed showed evidence of links to a range of assessment processes. However, there were some aspects of the plans that do not meet requirements. For example:</p> <ul style="list-style-type: none"> • Goals within the service delivery plans are not all consumer focused with overuse of the words 'maintain and 'retain' and limited evidence of an intention to promote positive changes for the resident(s). • The wording in residents' goals overall is generalised, at times generic for a number of residents, and does not always demonstrate individualisation. • Not all person-centred care plans reflect all of residents' assessed physical, psychosocial, spiritual and cultural abilities, deficits and needs, actual or potential <p>problems/deficits identified. (Refer D16.3 I and j of the Aged Related Residential Care Agreement). Interventions do not inform how these will be addressed, or how</p> <p>any change will be implemented.</p>	<p>Not all aspects of the service delivery plans meet the requirements of the standard and the ARRC agreement as many personal goals are generic and lack prospective improvement and direction; interventions are generalised and do not consistently show individualisation and there are care plans that do not reflect activity planning or acknowledgement of individual values and beliefs.</p>	<p>Service delivery plans are personalised, sufficiently detailed to ensure adequate resident care and are based on individual goals that include residents' assessed physical, psychosocial, spiritual and cultural abilities, deficits and needs, and actual or potential problems/deficits, as required in the ARRC agreement.</p> <p>90 days</p>
<p>Criterion 1.4.7.5</p> <p>An appropriate 'call system' is available to summon assistance when required.</p>	<p>PA Moderate</p>	<p>Issues with the malfunction of the call bell system were evident on the day of audit. These had already been identified at an internal audit. These have yet to be rectified and meantime provide a risk to residents and to staff as they are required to regularly reset the system from a point</p>	<p>An appropriate call bell system is not always available for residents to summon assistance and the current malfunction issues put both residents and staff at risk.</p>	<p>Resolve the call bell issues to ensure residents can summon assistance when required.</p> <p>90 days</p>

		in an attic some distance away.		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.4.5</p> <p>The importance of whānau and their involvement with Māori consumers is recognised and supported by service providers.</p>	CI	<p>The diversional therapist has proactively worked to ensure the importance of whānau, including in its broader sense is foremost within this facility, in particular within the dementia service. A well-presented album of laminated photographs, Māori designs and artwork and patches of written information of two significant projects that were led by the diversional therapist was reviewed and discussed. One project was initiated to respond to the high occupancy of Māori residents alongside the high numbers of Māori staff. This involved a day focused on Matariki, which included a lunch of Māori kai (hangi and boil up) with up to 115 family members, residents and staff dining together in celebration of the day. An article on the initiative was in the local newspaper. The evaluation process stated that despite some initial resistance, the bringing together of whānau/families was described as 'beautiful', noted that many people had learned the</p>	<p>Dunblane Lifecare staff became involved in two significant projects, one of which involved bringing whānau/families into the facility to celebrate the significance of Matariki and the other involved the integration of children from a local school into the activity programme of the dementia service, while at the same time promoting use of te reo. These projects demonstrated continuous improvement as the importance of the involvement of whānau for Māori residents was proactively recognised and supported by the staff. Evaluation processes showed the benefits to residents, especially those who identify as Māori and have dementia, and the appreciation of whānau in the wider context.</p>

		<p>meaning and significance of Matariki and stated how much respect was demonstrated. The conclusion was that it would be repeated next year.</p> <p>The other project was in 2017 and was initiated after a conversation between a family member and the diversional therapist. With the high occupancy of residents who identify as Māori, there are a number of residents within the dementia service who speak te reo at times. Waikirikiri School is bilingual and for a period of time tamariki/children from the school came once a fortnight to do things such as crafts and singing with the residents from the dementia service. During these visits they interacted with the kaumatua and kuia in this dementia service in te reo. Prior to the visits, information about dementia had been provided to the teachers, who passed it onto the tamariki/children. This project also featured in the local newspaper. There was some negative feedback; however, overall the evaluation described it as a successful initiative with grandparent type relationships having been formed and an increased knowledge being obtained for those involved both within the school and the dementia service. The evaluation described the 'wonderful' feedback about the process including expressed appreciation of the efforts made from families and the wider community. A comment noted how it had been extremely rewarding to see the receptivity of the residents, changes on the faces of the residents, especially those who were fluent in te reo and the willingness of these residents to participate, including responses in te reo. The conclusion was that its high level of success suggests it needs to be repeated but next time to include the entire facility and not just the dementia service.</p> <p>These two initiatives have contributed to this standard gaining a rating of continuous improvement.</p>	
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End of the report.