

G J & J M Bellaney Limited - Wimbledon Villa

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: G J & J M Bellaney Limited

Premises audited: Wimbledon Villa

Services audited: Hospital services - Medical services; Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 26 September 2019 End date: 27 September 2019

Proposed changes to current services (if any): The service is also certified for hospital - Geriatric services. This is not included in the table above. Two resident rooms (in the dementia wing) altered due to the reconfiguration of rooms were assessed as suitable for dementia care residents.

Total beds occupied across all premises included in the audit on the first day of the audit: 31



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

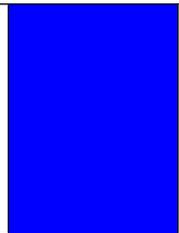
Wimbledon Villa is privately owned and provides rest home, dementia and hospital level of care for up to 38 residents. On the day of the audit, there were 31 residents. A clinical nurse manager and business manager are responsible for the daily operation of the facility. They are supported by a clinical team leader and internal auditor, registered nurses and care staff. Family members and residents interviewed spoke positively about the care and services provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff, management and the general practitioner.

This audit did not identify any areas for improvement.

The service has been awarded continuous improvement ratings around good practice and reducing challenging behaviours.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code. The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate, their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Examples of good practice were provided. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The business manager and clinical nurse manager are responsible for the daily operation of the service. They are supported by a clinical team leader and internal auditor. Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme are embedded. Data is collected, analysed, discussed and changes made as a result of trend analysis. There is a health and safety management programme available to guide staff. Resident/family meetings are held two monthly. Incidents and accidents are reported. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive

appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training are in place, which includes in-service education and competency assessments. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete interRAI assessments, and care planning. Care plans demonstrate service integration. Care plans were updated for changes in health status.

The activity programmes meet the ability and needs of residents. There is provision for group and individual one-on-one activities. There is a separate programme for the rest home/hospital residents and the dementia unit. There were 24-hour activity plans for residents in the dementia care unit that were personalised for their needs.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

A dietitian reviews the menu. Individual and special dietary needs are accommodated. Nutritional snacks are available 24-hours for residents in the dementia unit. Residents interviewed responded favourably to the food provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Wimbledon Villa has a current building warrant of fitness. Reactive and preventative maintenance occurs. Medical equipment and electrical appliances have been calibrated. All bedrooms are single occupancy. There is sufficient space to allow the movement of residents around the facility using mobility aids including for residents at hospital level care in any of the dual-purpose rooms. There are lounge, low stimulus areas and dining areas throughout the facility. There is a designated laundry at the site, which includes the safe storage of cleaning and laundry chemicals. There is a documented process for waste management. External garden areas are available with suitable pathways, seating and shade provided. Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days.

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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Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit, there were no residents with restraint and no residents using enablers. Staff training has been provided around restraint minimisation and management of challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all staff as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Benchmarking of results occurs.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	44	0	0	0	0	0
Criteria	2	92	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Wimbledon Villa policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information in the welcome pack on admission which includes information about the Code.</p> <p>Staff receive training about resident rights at orientation and as part of the two-yearly in-service programme last in December 2017.</p> <p>Interviews with care staff (two healthcare assistants, two registered nurses (RNs), one clinical team leader and the diversional therapist), confirmed their understanding of the Code. Seven relatives interviewed (three hospital and four of dementia care residents) confirmed that staff respect privacy, and support residents in making choices.</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</p>	FA	<p>The service has a policy in place for informed consent and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. Written consents are included in the admission agreements, which are signed on admission to the service and includes the use of social media. The advanced directives/resuscitation policy was implemented in the resident files reviewed. Informed consent processes are discussed with residents and families on admission. The</p>

<p>give informed consent.</p>		<p>residents in Courtyard Villa (dementia) have activated enduring powers of attorney (EPOA) in place.</p> <p>Interviews with healthcare assistants and residents identified that consents are sought in the delivery of personal cares. Discussion with relatives identified that the service actively involves them in decisions that affect their relative's lives.</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>Advocacy information is available to residents in the service entrance. Interviews with residents and family confirmed they were aware of their right to access advocacy. A policy describes access to advocacy services. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. The resident files reviewed included information on the resident's chosen networks. Staff training in Code of Rights and advocacy has been provided.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in community groups such as senior citizens, Alzheimer's society and local churches. Relatives and friends are encouraged to be involved with the service and care.</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 service has a complaints policy that describes the management of the complaints process. Information about complaints is provided on admission to residents and their families/whānau. Feedback forms are available for residents and families/whānau at both entrances to the facility. All staff interviewed were able to describe the process around reporting complaints. There is a complaint's register. One complaint had been made in 2018 and three complaints in the year-to-date. All complaints reviewed had written investigations, met timeframes and where required, corrective actions were documented and implemented. Results and outcomes of the investigations are fed back to complainants. Complainants are offered independent advocacy. Discussions with residents/relatives confirmed that any issues are addressed, and they feel comfortable to approach management and staff if they have any concerns.</p> <p>There has been one request (June 2018) from the privacy commissioner regarding relative access to records. The request has been completed and the privacy commissioner is in the process of signing off the request.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. Residents (two rest home and one hospital) and relatives interviewed confirmed that information had been provided to them around the Code and they have the opportunity to discuss aspects of the Code during the admission process. Posters of the Code and advocacy information is displayed at both entrances (rest home/hospital and dementia care). Families and residents are informed of the scope of services and any liability for payment for items not included in the scope which is included in the admission agreement.</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>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe on interview how they manage to maintain privacy and respect of personal property. Three residents interviewed and family members stated staff were very respectful and maintained resident dignity at all times. Staff receive training around privacy and dignity and elder abuse and neglect is part of the training programme.</p> <p>Resident preferences are identified during the admission and care planning process and this includes family involvement. Interviews with healthcare assistants described how choice is incorporated into resident cares.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are supporting policies that acknowledge the Treaty of Waitangi, provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. The policies for Māori identify the importance of family/whānau. Staff receive cultural training provided by Te Runanga O Raukawa (local Iwi). Staff complete a cultural safety workbook. There were two Māori residents on the day of audit. Cultural preferences and support were identified in the cultural needs section of the long-term care plan.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>Information gathered during assessment including residents' cultural beliefs and values, is used to develop a care plan. The resident (as appropriate) and family are invited to be involved in care planning. Beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews are scheduled, and family are invited to attend. Relatives and residents interviewed confirmed that staff take into account their culture and values. Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Job descriptions include responsibilities of the position and responsibilities in terms of providing a discrimination free environment. Staff sign a code of conduct, house rules, confidentially and non-disclosure agreements on employment. Comprehensive policies and procedures provide guidelines and mentoring for specific situations. Interviews with staff confirmed an awareness of professional boundaries. Training is provided as part of the staff training and education plan. Discussions with competent residents identified that they are treated fairly without any discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>CI</p>	<p>The service has policies to guide practice that aligns with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Allied health professionals are available to provide input into resident care. The service has participated in the SEQUAL programme developed by hospice to provide optimum care and comfort for residents on palliative care. The service was awarded the Best Aged Care small facility award through aged advisor website.</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>Relatives and residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Eleven incidents/accident forms reviewed for August 2019 included a section to record family notification. All forms evidenced family were informed. Relatives confirmed that they are notified of any changes in their family member's health status. There are residents' meetings held two monthly in the Rose wing (rest home/hospital). Relative meetings are held two monthly in the Courtyard Villa. Two monthly newsletters are distributed to families keeping them informed on the services, provided and facility matters.</p> <p>Interpreter services are used where indicated.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	<p>FA</p>	<p>Wimbledon Villa is privately owned. The proprietor (not based on site) has overall financial and governance responsibility. The proprietor is kept informed on facility matters and all essential reporting and visits regularly. He is readily available by phone and there are regular teleconferences with the management team.</p>

<p>appropriate to the needs of consumers.</p>		<p>The service provides rest home, hospital and dementia level of care for up to 38 residents. There is an 18-bed dual-purpose (rest home/hospital) wing and a 20-bed secure dementia care wing. On the day of the audit, there were 31 residents in total, five residents at rest home level, 10 residents at hospital level and 16 dementia level residents (including one respite care). There were three younger people in the dementia care unit on a 'like in age and interest' contract.</p> <p>There is a business marketing plan 2019-2020 that includes the business values, objectives and goals. These are developed in consultation with the business manager and clinical nurse manager and include achieving above 80% in the satisfaction survey, increasing staff skills and knowledge around palliative care and reviewing the activity programme. The service has purchased additional hospital level beds and pressure relieving equipment. There are regular heads of department meetings where goals and objectives are reviewed and monitored for progress.</p> <p>The business manager (non-clinical) has been in the role for nine years. The business manager is supported by a clinical nurse manager who has been in the role for seven years and has a postgraduate diploma in healthcare and considerable background in aged care. The management team are supported by an internal auditor employed for 14 hours per month and oversees the internal auditing programme. There is a clinical team leader/registered nurse who works Tuesday to Saturday.</p> <p>The clinical nurse manager and business manager have attended at least eight hours of professional development relevant to the role and both attend the DHB provider forums.</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>The clinical nurse manager covers during the temporary absence of the business manager. The clinical team leader covers the clinical nurse managers leave.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that</p>	<p>FA</p>	<p>There is a documented quality and risk management system. The content of the policies and procedures is detailed to allow effective implementation by staff. The service contracts an aged care consultant to develop and review policies and procedures which are available on the intranet. Staff are informed of any policy updates.</p> <p>The quality and risk management system is designed to monitor contractual and standards</p>

<p>reflects continuous quality improvement principles.</p>		<p>compliance and includes audit requirements for the month. The internal auditor (non-clinical) coordinates and completes non-clinical audits, collates results and reports outcomes and any corrective actions which are signed off when completed.</p> <p>All quality data for adverse events, incidents/accidents, infections and medications are entered into a monthly events log which is submitted for benchmarking against industry standards. A monthly report for trends is completed and reported to the facility meetings. There is a six-monthly analysis of all data and there are graphs and monthly comparisons made available on the intranet. The service has been successful in reducing challenging behaviours.</p> <p>Annual resident/relative satisfaction surveys are completed with results communicated to residents and relatives. The 2019 survey resulted in 85% overall satisfaction compared with 80% in 2018. The business goal of achieving over 80% satisfaction has been achieved. Collation of returns identified that 50% returns were from relatives of the dementia care residents.</p> <p>There is a health and safety and risk management programme in place including policies to guide practice. The health and safety representative (senior HCA) has been in the role two years and coordinates the fire drills and site inductions for orientating staff and contractors. Staff are informed of upcoming meetings and raise any health and safety concerns with the health and safety representative for discussion at the team meeting. Hazards are reported and if unable to be eliminated are added to the hazard register. The hazard register was last reviewed August 2019. The business manager has attended business continuity emergency planning for aged care this year.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Individual reports are completed for each incident/accident with immediate action noted and RN follow-up/action as required. On interview, care staff understood what an accident and incident was and actions to be taken. Ten accident/incident forms (unwitnessed falls, skin tears and one pressure injury) were reviewed for August 2019. Each event reflected a clinical assessment and follow-up by a registered nurse (RN). Data collected on the electronic incident and accident system is linked to the quality management system. Monthly trends and analysis were completed and reported back to the staff. Corrective actions are implemented where results are above the industry standard. Neurological observations were completed for unwitnessed falls and where there was an obvious knock to the head.</p> <p>Discussions with the clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been five Section 31 notifications since the last audit (one behavioural that involved two residents, one unstageable pressure injury, one missing resident and one RN shortage on night shift). There was a notification</p>

		to the public health for an outbreak August 2019.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Six staff files reviewed, including one clinical team leader/RN, one RN, two HCAs, one diversional therapist and one cook evidenced employment contracts, police checks and references and job descriptions. A register of registered nursing staff and other health practitioner practising certificates is maintained. Staff complete a three-day orientation which includes site orientation and role specific orientation. The orientation programme includes documented competencies and induction checklists. Staff have a three-month appraisal and annually thereafter.</p> <p>The annual education plan for 2018 was completed and the 2019 education plan has been completed to date. The education programme covers the mandatory requirements at least two yearly. Medicine management, infection control and challenging behaviour education is provided annually. The clinical nurse manager has developed workbooks for all education sessions, and these are completed by staff who are unable to attend the education session. Staff complete competencies relevant to their role such as hand hygiene, medication, syringe driver and safe manual handling. There is the opportunity to attend external training. Individual education records are maintained.</p> <p>A quality initiative being developed is to assign “champions” (one RN and one HCA) for key roles. There are nine RNs including the clinical nurse manger and clinical team leader. There are three interRAI trained RNs (including the clinical nurse manger and clinical team leader). One RN is currently in training and another is registered to attend training.</p> <p>There are 15 HCAs that work in the dementia unit. Ten HCAs have completed the required dementia standards. There are two HCAs currently undertaking the training with Careerforce and two enrolled to commence. One HCA is newly employed and yet to enrol. The clinical nurse manager is a Careerforce assessor.</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>	FA	<p>There is a safe staffing policy and procedure, which describes staffing, and this can be increased if resident acuity demands. The business manager and clinical nurse manager both work full-time Monday to Friday and are available on call for any emergency issues. The clinical nurse manager and clinical team leader share the on-call for clinical matters.</p> <p>There is an RN on duty 24 hours in the rest home/hospital Rose Wing. The clinical team leader is based in the dementia care wing – Courtyard Villa, from Tuesday to Saturday. Clinical support for the dementia wing is provided by the clinical nurse manager on Mondays and the hospital RN on</p>

		<p>Sundays. The hospital RN oversees the dementia wing on afternoons and nights.</p> <p>In the dementia unit (16 residents) there are two HCAs on the morning shift, three HCAs (one from 4.30 pm to 8.30 pm) on the afternoon shift and two HCAs on the night shift.</p> <p>In the rest home/hospital (5 rest home, 10 hospital) there are two HCAs on morning, two HCAs (one from 5 pm – 8 pm) on afternoon shift and one HCA on night shift.</p> <p>Staff interviewed stated there were enough staff on duty and staff sickness/vacant shifts are covered. Relative and residents stated there were adequate staff on duty.</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>	FA	<p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Files are integrated. Electronic information is password protected.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack with information around admission processes and entry to the service. This includes information on the dementia care secure wing. All residents are screened prior to entry by the business and clinical manager, to ensure they meet rest home, hospital, or dementia level care. Six files sampled (two hospital, two rest home and two dementia level care including one resident on respite care) evidenced processes are being followed and admission agreements signed. Exclusions from the service and special charges are included in the admission agreement.</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>The registered nurses interviewed described the nursing requirements as per the policy for discharge and transfers. The 'pink transfer envelope' is used, and includes a completed transfer form, the advanced directive and resuscitation status are included along with the medication chart and any other relevant information.</p> <p>Transfer to another facility or home following respite is planned and the relatives are well informed to ensure a smooth transition.</p>
<p>Standard 1.3.12: Medicine</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>requirements. The service uses individualised blister packs for regular and 'as required' (PRN) medications. Medication reconciliation is completed by the registered nurse on delivery of medication and any errors are fed back to pharmacy. All medications were securely and appropriately stored in both areas on the day of audit. All registered nurses and HCAs who administer medication had been assessed for competency for medications and insulin on an annual basis. RNs have completed syringe driver training.</p> <p>Twelve electronic medication charts were reviewed (four rest home, four hospital, and four dementia). The service uses an electronic medication management system. The medication charts reviewed were clearly documented, signing sheets. The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly.</p> <p>Staff were observed to be safely administering medications. Registered nurses and HCAs interviewed, could describe their role in regard to medicine administration. Standing orders are not used. There were no self-medicating residents at the time of audit.</p> <p>The medication fridge temperatures are recorded weekly and these were within acceptable ranges. There is a signed agreement with the pharmacy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a small well-appointed kitchen located in the Courtyard Villa. All meals are cooked on site for the facility. Staff working in the kitchen have food safety certificates (NZQA). A current food control plan is in place. Food is served from the kitchen to the adjacent dining area and transported in hot boxes to the Rose wing.</p> <p>A nutritional assessment is completed by the registered nurse as part of the assessment process and this includes likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. This includes consideration of any dietary needs (including cultural needs). This was reviewed six-monthly as part of the care plan review or sooner if required. The menu is a four-weekly seasonal menu. The menu was designed and reviewed by a registered dietitian. There was evidence of residents receiving supplements. Fridges and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridges was covered and dated. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Special or modified diets are catered for. Soft and pureed dietary needs are documented in files reviewed. There is evidence that there are additional nutritious snacks available over 24-hours.</p>
<p>Standard 1.3.2: Declining</p>	FA	<p>The service records the reasons for declining service entry to prospective residents should this occur and communicates this to prospective residents/family/whānau. The reasons for declining entry</p>

<p>Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred to the referring agency if entry were declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files reviewed across all three service levels identified that risk assessments have been completed on admission and reviewed six monthly as part of the evaluation. Additional assessments for management of behaviour, depression assessment and chest infection risk was appropriately completed according to need. Five of six resident files reviewed contained long-term care plans and interRAI assessments. One dementia care resident was a short-term respite admission and did not require an interRAI. InterRAI initial assessments and assessment summaries were evident in printed format in all permanent resident files. For the resident files reviewed, the outcomes from assessments and risk assessments were reflected into care plans.</p> <p>The respite resident had an initial assessment, risk assessments, health status and clinical risk assessment completed on admission.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long-term care plans reviewed were comprehensive and demonstrated input from allied health in all five long-term files reviewed. Resident care plans sampled were resident-centred and support needs were documented in detail. The two dementia resident files reviewed identified current abilities, level of independence, identified needs and specific behavioural management strategies. All six resident files indicated family involvement. Relatives interviewed confirmed care delivery and support by staff was consistent with their expectations.</p> <p>A variety of short-term care plans are pre-populated on the electronic system and can be individualised to specific resident need, printed and kept in a separate file. Short-term care plans reviewed had been evaluated at regular intervals and either resolved or added to the long-term care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet</p>	<p>FA</p>	<p>When a resident's condition alters, the RN initiates a review by the GP. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met.</p> <p>Wound assessments, treatment and evaluations were in place for all five current wounds across the</p>

<p>their assessed needs and desired outcomes.</p>		<p>facility. There were no pressure injuries on the day of the audit. The GP was notified of all wounds, and the wound care specialist had been involved with chronic wounds. Adequate dressing supplies were sighted in the treatment rooms. Staff receive regular education on wound management.</p> <p>Continence products are available and resident files includes urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>All weight is monitored monthly. When weight loss is identified, the clinical team requests dietitian involvement. Weight loss is discussed at RN clinical meetings.</p> <p>The nurse practitioner for mental health of the older person and psychiatrist were involved with residents in the Courtyard Villa when required. Low stimulus environments are well utilised by residents as observed throughout the audit in Courtyard Villa.</p> <p>Monitoring forms in place included (but were not limited to): monthly weight, blood pressure and pulse, food and fluid charts, repositioning, blood sugar levels and behaviour charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one diversional therapist employed at Wimbledon Villa, who provides activities over five days a week, with the healthcare assistants providing activities over the weekend. The diversional therapist discusses the programme at the resident's meetings and one-on-one with residents to gain feedback. Changes are made to suit resident requests and consider resident abilities and cover physical, social, recreational and emotional needs of the residents.</p> <p>The activities programme changes to suit current resident ability and preferences as much as possible. Activities include daily walking group for both wings within the facility during the winter months and outside during the summer months, entertainment, crafts, baking, pet therapy and church services.</p> <p>The diversional therapist seamlessly divides her time between the two units throughout the day. Activities were observed to be delivered simultaneously throughout the facility. Daily contact is made, and one-on-one time is spent with residents who are unable or decline to participate in group activities. One volunteer was involved assisting with the activities programme.</p> <p>In the dementia unit the diversional therapist leads the activities. Residents were sighted engaging with staff in a variety of activities during the audit. Healthcare assistants were involved in the activities over a 24-hour period and have individual activities that can be carried out with residents on a one-on-one basis. Healthcare assistants were observed at various times throughout the day diverting residents from behaviours. Music therapy is available as a form of distraction.</p>

		<p>Activity assessments are completed for residents on admission. The activity plans in the files reviewed, had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate, are involved in the development of the activity plan.</p> <p>Residents/relatives can feedback on the programme through the resident meetings and satisfaction surveys. The diversional therapist interviewed, stated that she was well supported in her role by management. Residents and relatives interviewed stated satisfaction with activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed had been evaluated by registered nurses at least six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans reviewed for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves the clinical manager, RN, healthcare assistant, diversional therapist and the team leader. The relative/NOK are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits, and were updated of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the review of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the physiotherapist, mental health support of the older persons (DHB), dietitian, wound care specialist and podiatrist. There was evidence of GP discussion with residents and relatives regarding referrals for treatment and options of care.</p> <p>Discussions with registered nurses identified that the service has ready access to nursing specialists such as wound, continence, palliative care and diabetes. The physiotherapist is available as needed and was involved with a resident currently.</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,</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves and aprons are available, and staff were observed wearing personal protective clothing while carrying out their duties. Clear plastic splash guards are in place in the sluice rooms. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety datasheets were available.</p>

generated during service delivery.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness, which expires on 8 July 2020. Reactive and preventative maintenance occurs. Electrical equipment has been tested and tagged. Medical equipment has been calibrated by an authorised technician. Hot water temperature has been monitored monthly in resident areas and was within the acceptable range. There is a designated maintenance person who works part time over three days a week.</p> <p>Wimbledon Villa has two wings. Courtyard Villa (dementia) has 20 single occupancy rooms. The Rose (rest home and hospital) wing has 18 single occupancy rooms. The plan of the building is based on the Hammond care design. There are paved looping walkways in the courtyard areas of Courtyard Villa with gates, and paths and no dead ends. There are well maintained raised flower beds, water features and handrails. Ten of the resident rooms have external access to the internal courtyard area. The secure garden at the front of the facility is based on garden plants from the resident's era that they grew up with. Ramp access and pathways lead residents through the gardens with no dead ends. Shade at the front of the facility is provided in the seating area under the veranda. Wimbledon Villa is smoke free.</p> <p>The service is trialling large posters on residents' doors of something meaningful to that resident, there were full length posters of family members, churches, guitars to guide residents in the Courtyard wing to their rooms.</p> <p>The large lounge space in Courtyard Villa has been reconfigured to include three resident bedrooms (one existing and two new rooms), and a smaller quiet lounge, and a quiet seating area at the front entrance. This has not altered the bed numbers. The new rooms have calls bells and are spacious enough for residents to move about with mobility aids if required. The new smaller seating areas were well utilised by residents during the audit. There is a separate lounge space utilised for resident activities, and a screen can be utilised to create two smaller spaces if required.</p> <p>The Rose wing has a separate lounge and dining area, residents were observed participating in group activities in the lounge area during the audit. External areas were also well maintained and provide seating and shade. All communal areas were accessible to residents using mobility aids.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Residents were observed moving freely around the areas with mobility aids where required.</p>
Standard 1.4.3: Toilet, Shower, And	FA	There are large communal toilets in both wings including wet area shower rooms. Rose wing has six

<p>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>rooms with ensembles, and six rooms in Courtyard Villa with ensembles. There were shared facilities available within close proximity for the rooms without ensuite facilities. The communal facilities are close enough and large enough to meet the needs of the residents. Fixtures, fittings and floor and wall surfaces are made of accepted materials for meeting hygiene and infection control practices. Communal toilets and showers are well signed and identifiable. There are engaged/vacant signs on the doors and privacy curtains. There are appropriately placed handrails in the bathrooms and toilets in the ensembles and communal areas.</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>	FA	<p>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. All resident beds are either electric hospital hi/low beds or manual beds, where height can be adjusted to suit resident need. Residents are encouraged to personalise their bedrooms. Staff and residents interviewed confirmed the bedrooms are large enough for mobility and manual handling equipment.</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>	FA	<p>The Rose wing has a kitchenette area where the meals are served from one end of the designated dining area. There is a lounge area separate from the dining area for residents to enjoy television or group activities.</p> <p>Courtyard Villa has separate lounge and dining areas. There is a small kitchenette area in the larger lounge in the Courtyard Villa used for activities. A separate small quiet lounge area is just off of the dining area, and there is another small quiet seating area at the main entrance to Courtyard Villa.</p> <p>Furniture is arranged to allow residents to freely mobilise between the different areas of each wing and to the outside garden areas. In both wings, the lounges are accessible and accommodate the equipment required for the residents.</p> <p>There are cameras in areas away from the main lounges connected to surveillance monitors for resident safety. Residents have easy access to secure outdoor areas.</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</p>	FA	<p>The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>Personal laundry and towels are laundered on site by staff. Residents and relatives interviewed were satisfied with the laundry service. The linen is laundered off site. On the day of the audit there</p>

which the service is being provided.		was a good supply of clean linen in the linen cupboards. Staff interviewed reported there is always a good supply of clean linen.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service dated 2 May 2015, post reconfiguration/refurbishment of beds in the rest home and dementia care wings. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation drills occur. The facility has emergency lighting, one generator, stored water and food for at least three days and a gas BBQ for alternative cooking, which can be used in the event of an emergency. Civil defence supplies are readily accessible and checked regularly. The staff interviewed could describe the emergency management plan and how to implement this. Emergency training is provided six monthly in combination with the fire drill. There is a qualified first aid trained staff member on each shift.</p> <p>There are call bells in the residents' rooms, toilets/shower rooms and communal lounge/dining room areas. Call bell audits are conducted monthly.</p> <p>There are double keypad secure gates into the secure dementia unit. There is free entry/exit into the rest home/hospital wing. The internal adjoining door between the rest home/hospital and dementia wing is secure by keypad. There are security cameras placed in public areas.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All rooms have external windows that open, allowing plenty of natural sunlight. Communal areas and resident rooms are appropriately heated by heat pumps or ceiling heaters. The temperature can be individually adjusted in the resident bedrooms. Residents and relatives interviewed stated the environment was warm and comfortable. Air temperatures are checked and recorded on a monthly basis.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail is appropriate for the size, complexity, and degree of risk associated with the service. The clinical nurse manager is the designated infection control coordinator with a job description that outlines the responsibility of the role. The infection control team includes management and all staff who meet annually to review the infection control programme (last August 2019). Infection control reports and analysis are discussed and reported at the monthly team meetings.</p> <p>There are hand sanitisers placed throughout the facility. Visitors are asked not to visit if unwell.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical nurse manager is a member of the NZNO infection control interest group and receives current information through this group. She has attended external infection education in November 2018. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator has good external support from the infection control nurse specialist at the DHB, aged care consultant, local laboratory, GP and public health.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies and procedures appropriate for the size and complexity of the service. They have been developed by an aged care consultant and reflect current best practice including standards and guidelines, defining roles, responsibilities and oversight and training and education of staff. The policies have been reviewed and updated annually.</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>All staff complete an orientation covering infection control practises and hand hygiene competences. All staff complete annual competencies around the correct use of personal protective equipment and hand hygiene. There is annual infection control education scheduled with the last provided August 2019. An outbreak debrief was held with the public health following an outbreak.</p> <p>Resident education occurs as part of the daily cares. Infection control matters are discussed at resident/relative meetings and published in the two monthly newsletters.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information monthly and enters data into the electronic system for benchmarking. Corrective actions are established where infections are above the benchmark. The monthly analysis and graphs are attached to the team meeting minutes for staff information.</p>

<p>that have been specified in the infection control programme.</p>		<p>Surveillance data are used to determine infection control activities and education needs in the facility. Definitions of infections in place are appropriate to the complexity of service provided. Infection control data, identified trends, and analysis are reported at the team (all staff) meetings and reviewed at the fortnightly RN meetings. Monthly comparison and trends for infection rates are also analysed on an individual basis. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There has been one influenza outbreak August 2019. The public health was notified, and daily case logs and reports sighted. The service was compliant with policies and procedures for outbreak management.</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>There are policies and procedures in place should enablers or restraint be required. The clinical nurse manager is the restraint coordinator. On the day of audit there were no residents requiring the use of restraint or enablers. Restraint/enabler use is discussed at the monthly team meetings. The approval group meet annually to review policies, procedures and any education opportunities. Care staff complete a restraint competency on orientation and annually. Challenging behaviour and de-escalation techniques is included in the training programme.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>Arohanui Hospice and Wimbledon introduced the SEQUAL (supportive education and quality palliative care) programme with the aim of early recognition of residents entering palliative care with improved</p>	<p>The SEQUAL programme commenced late 2018 with an action plan around to increase staff knowledge and skills around palliative care assessments. Areas for improvement were identified by an internal audit of files of deceased residents. The SEQUAL clinical nurse specialist (CNS) coordinated a separate but paralleled education programme for the RNs and the HCAs with the last session being combined. The SEQUAL CNS and RN colleague worked all shifts alongside staff supporting them and getting to know residents and the levels of care provided at Wimbledon. A facility specific resource folder was put together and included an assessment tool which is used for all new and existing residents to identify early support and interventions for residents entering the palliative phase of their life. An end of life care plan is developed and implemented as soon as residents are identified as palliative care. The GP was informed of the SEQUAL programme and newsletters were sent out to families informing them of the aim and benefits of the programme. All registered nurses have completed syringe driver training. The SEQUAL programme has been in place since January 2019. There have been many positive outcomes including identifying residents entering the last six months of their life and planning around this event involving the resident and their family. There is more understanding and knowledge about palliative care and the nurses and staff now feel more confident in providing end of life care which was confirmed by the GP (interviewed). The knowledge around symptom control has increased and conversations around these matters have improved allowing resident and family involvement. The service has appointed the</p>

		care, symptom control, communication and support for the resident and family.	clinical team leader (who completed RN placement at the hospice) and senior HCA (who has completed palliative care modules) as care “champions”. They meet monthly with the CNS and review residents who have been assessed as entering the palliative phase of their lives. An audit on five resident files (now deceased) pre and post SEQUAL, evidenced an improvement in prescribing end of end of life medications and ‘as required’ medications, family involvement, end of life care plans, information on bereavement support given to family and specialist palliative care advice sought. Currently five residents are on the programme who are entering the last six months and are receiving appropriate care and support.
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The adverse events analysis for behaviour of concern for the January to March 2019 quarter identified an upwards trend. A corrective action was implemented, and the challenging behaviours have reduced below the industry key performance indication of three per month.	The quarterly analysis for challenging behaviours identified an upward trend in the dementia wing. The time of most incidents occurred between 3pm – 9pm when staff were receiving handover and attending to residents. Staff duty guidelines were re-written to include a focus on modelling desirable behaviour such as sitting with residents, one-on-one time with activities, re-orientation of residents to the environment. A staff member has been allocated to the lounge between 3pm – 6pm when most residents are active. The DT is based in the dementia care wing from 3pm – 5pm. There was a slight downward trend in the second quarter report. A spike in challenging behaviours in July was attributed to a respite care resident who then became permanent and settled under GP care and review of medications. For August and September there had been a large reduction in challenging behaviours to below the industry KPI. This demonstrated staff compliance with supports, activities and resident supervision between 3pm – 9pm.

End of the report.