

G&M Wellbeing Limited - Dominion Home

Introduction

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

The audit has been conducted by 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&M Wellbeing Limited

Premises audited: Dominion Home

Services audited: Dementia care

Dates of audit: Start date: 18 September 2019 End date: 18 September 2019

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 27

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

Dominium Home provides dementia level of care for up to 29 residents. On the day of audit there were 27 residents.

This certification audit was conducted against the Health and Disability Services Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, general practitioner and staff.

The service is managed by an owner/manager/registered nurse (RN) and a facility manager/RN. Family and the GP interviewed all spoke very positively about the care and support provided.

One improvement is required in relation to staff education and training.

There are two areas of continuous improvement awarded around reducing the number of residents' falls, and the activities programme and the food.

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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Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service complies with the Code of Health and Disability Consumers' Rights. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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A service philosophy and specific aims for the year are in place. Quality activities are regularly conducted. Meetings are held to discuss quality and risk management processes. Residents' meetings are also held, and families are surveyed annually. Incidents and accidents are reported. An education and training programme is established. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

All standards applicable to this service fully attained with some standards exceeded.

There is an admission pack that provides information on entry to the service. The registered nurse is responsible for the provision of care and documentation at every stage of service delivery. Sufficient information is gained through the initial support plans, specific assessments, discharge summaries and the care plans to guide staff in the safe delivery of care to residents. The care plans are resident and goal orientated. Care plans are reviewed every six months or earlier if required. Files reviewed identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months.

The activities coordinator delivers a varied activity programme to meet the individual needs, preferences and abilities of the resident groups. The programme encourages the maintenance of community links and family participation. There are regular entertainers, outings, and celebrations.

Medications are managed appropriately in line with accepted guidelines. The registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

All meals and baking are prepared on site by an experienced cook. There is a current food control plan in place. Resident dietary needs and resident preferences are catered for. There are nutritious snacks available 24 hours.

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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There is a current building warrant of fitness. All resident rooms have sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents rooms are personalised. There is a large central lounge and dining that opens out into secured outdoor gardens. Furniture is appropriate to the setting and arranged in a way that allows residents to mobilise. Chemicals and cleaning trolleys are stored securely when not in use. The service has implemented policies and procedures for civil defence and other emergencies. There is a first aider on duty at all times. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, security, seating and shade provided.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents using restraints or enablers.

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.

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (owner/manager/registered nurse) is responsible for coordinating the infection control programme and providing education and training for staff. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. Information is obtained through surveillance to determine infection control activities.

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	43	0	1	0	0	0
Criteria	2	90	0	1	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>The Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with six staff (three caregivers, one activities coordinator, one cook, and one maintenance staff) confirmed their familiarity with the Code. Interviews with seven family members confirmed that the services being provided are in line with the Code. Aspects of the Code are discussed at resident and staff meetings.</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</p>	FA	<p>The service has in place policies and procedures for informed consent and resuscitation, which meets the requirements of the Code. All six resident files reviewed, including one resident on respite and one resident on a long-term support chronic health conditions (LTS-CHC) contract, had completed written consents and general consents signed by their enduring power of attorney (EPOA). Advanced directives are in place where available. There was evidence of discussion with family when the GP completed a clinically indicated not for resuscitation order where residents were deemed not to be competent. There was a copy of the activated EPOA in all six resident files.</p> <p>The managers/RNs and caregivers interviewed confirmed verbal consent is obtained when delivering care. Discussions with family members identified that the service actively involves them in decisions that affect their</p>

consent.		<p>relative's lives.</p> <p>All six resident files reviewed had signed admission agreements.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the information provided during entry to the service and on complaints forms. Advocate support is available if requested. Interviews with staff and relatives informed they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in activities and maintain family and friends' networks. On interview, staff stated that residents are encouraged to build and maintain relationships. Residents and relatives confirmed this and provided examples of a variety of community functions and groups they attend. Visiting can occur at any time.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. There are complaint forms and a complaints box available at the entrance to the facility. Information about complaints is provided on admission. The owner/manager, and the facility manager operate an 'open door' environment, evidenced in staff interviews.</p> <p>Interviews with families demonstrated their understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register that is being implemented. One complaint has been received in 2019 (year-to-date) and three in 2018. Two complaints (one in 2019 and one in 2018) were reviewed. Documentation including follow-up letters and resolution demonstrated that both complaints were managed in accordance with guidelines set by the HDC.</p> <p>Complaints received are linked to staff meetings. Discussions with relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Posters display the Code and leaflets are available. On entry to the service, either the owner/manager/registered nurse (RN) or the facility manager/RN discuss aspects of the Code with the resident and the family/whānau. The service is able to provide information about the Code in different languages and/or in large print if requested. Written information is given to residents and next of kin/enduring power of attorney (EPOA) to read with the resident and discuss.</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 that align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting residents' privacy and could describe how they manage to maintain privacy and respect of personal property. All relatives interviewed stated the residents' needs were met and their privacy maintained.</p> <p>A policy describes spiritual care. Relatives interviewed indicated that each resident's spiritual needs are being met. An Anglican priest visits the facility two weekly.</p> <p>Staff received training around resident abuse and neglect. There have been no reported instances of either.</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>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan documented for the service. Activities include Māori entertainers. Staff training covers cultural safety. Discussions with care staff confirmed that they are aware of the need to respond to cultural differences. The service is able to access Māori advisors through the district health board and has links to local kaumātua.</p> <p>A Te Whare Tapa Whā model was planned and implemented, centred around the activities programme (link to CI 1.3.7.1).</p> <p>One resident identified as Māori. A Māori assessment has been completed that has included input from the resident and their whānau. No specific needs were identified.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive</p>	<p>FA</p>	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents and relatives interviewed reported that they were satisfied that their cultural and individual values were being met, and these were documented in care plans sampled. Various cultural days are celebrated at the facility via the activities programme.</p>

culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has implemented a code of conduct. The owner/manager and facility manager supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All relatives interviewed reported that the staff respect the residents. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct/house rules.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards. Staffing policies cover pre-employment processes and the new employee's requirement to attend orientation and ongoing in-service training. The facility manager is responsible for coordinating the internal audit programme. Staff meetings are conducted. There is a regular in-service education and training programme for staff. Staff interviewed stated that they feel supported by the managers.</p> <p>Evidence-based practice is evident, promoting and encouraging good practice. The roster indicates the on-call RN when an RN is not on site. A house general practitioner (GP) visits the facility once per week. The service receives support from the local district health board (DHB). Physiotherapy services are available as required. A podiatrist visits every six to eight weeks. The service has links with the local community and encourages residents to remain as independent as possible, respecting their limitations.</p> <p>Areas of exceeding the standards were identified around reducing the number of residents' falls (link 1.2.3.8), the activities programme (link 1.3.7.1) and meals and nutrition (link 1.3.13.1).</p> <p>Relatives and the GP interviewed spoke very positively about the care and support provided.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Relatives interviewed stated that they and the residents were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were viewed. The forms included a section to record family notification.</p> <p>A notification consent form identifies situations that family wish to be contacted. All ten incident/accident forms</p>

<p>conducive to effective communication.</p>		<p>reviewed indicated family were informed following an adverse event if they indicated that they wanted to be informed. Relatives interviewed confirmed they are kept informed of any changes in their family member's health status.</p> <p>Interpreter services are available if required. Family and staff are used in the first instance. Staff and family were used as interpreters. Communication is also available via pictures on cards.</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>Dominion Home provides dementia level of care to 29 residents and on the day of the audit there were 27 residents living at this facility. In addition, there were three residents who were attending as day care residents (the facility is contracted by the DHB to accept up to 10 day care residents.)</p> <p>Two residents were on the LTS-CHC contract and one resident was on respite. The remaining residents were on an age-related residential care services agreement (ARCC) contract.</p> <p>The care home has a 2019 business management plan in place that addresses establishing working relationships, improves resident occupancy, nursing documentation, the nursing station, policies and procedures, resident meals and kitchen staff, organisational culture, staff appearance and facility upgrades (internal and external). These business objectives are reviewed by the owners and facility manager three times a year.</p> <p>One owner is an RN and the facility manager is also an RN. Both individuals work five days a week (Monday – Friday) with occasional weekend visits. They share 24-hour call responsibilities when not available on site. They are supported by a residential care officer who also works as caregiver.</p> <p>The owner/manager and facility manager have both attended more than eight hours per year of professional development related to their work in aged care. They are supported through study days provided by the DHB (twice per year, six hours per session).</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</p>	<p>FA</p>	<p>The facility manager/RN and owner/manager/RN are both in charge Monday – Friday and cover for the other's absence.</p>

safe services to consumers.		
<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>A quality policy and plan are implemented for the service that includes quality goals and objectives. Quality indicator data are established for 2019. Each indicator is linked to a goal, measure and compliance level. Interviews with the managers and staff reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures are provided by an external consultant. A system of document control is in place with evidence of regular reviews. Staff are made aware of any policy changes through staff meetings, evidenced in meeting minutes.</p> <p>The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents, resident satisfaction and infection rates. Adverse events are also trended individually by resident. Internal audits regularly monitor compliance. Corrective actions are documented and signed off where areas are identified for improvement. Staff are kept informed regarding results via staff meetings and during staff handovers.</p> <p>Annual resident satisfaction surveys are completed. The 2019 family satisfaction survey results had only three surveys returned. Results were very positive. High levels of satisfaction were also identified during interviews with families. Families are reported as being very involved with the home. For example, they assist the activities staff with activities and outings. No corrective actions were identified.</p> <p>A health and safety programme is in place, which includes managing identified hazards. Two caregivers are designated health and safety representatives. A health and safety management systems assessment was recently completed on 4 September 2019. No corrective actions were identified. Health and safety training begins during staff orientation. It is discussed regularly in the monthly staff meetings and is a topic on the annual education calendar. The hazard register was last reviewed on 3 December 2018. It is updated as new hazards are identified.</p> <p>Falls prevention strategies include the identification of interventions on a case-by-case basis to minimise future falls. Falls rates are very low following implementation of a number of strategies. This has resulted in a rating of continuous improvement.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and</p>	FA	<p>Ten resident related incident forms were reviewed (eg, challenging behaviours, falls with suspected injury to the head, medication error, absconding resident). Each form reviewed (held electronically) indicated that immediate action had been taken, including half-hourly neurology observations for any suspected head injury. Incident forms are signed off by an RN (eg, facility manager or owner/manager).</p> <p>The service collects all incident and accident information and analyses the data. This information is reported to</p>

<p>reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>staff, evidenced in the staff meeting minutes.</p> <p>Discussions with the facility manager and owner/manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided (eg, electrical power interruption, absconding resident).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resource management policies in place that includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates were sighted for the two RNs and visiting health professionals. Five staff files (one cook, two caregivers, two floor assistants) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals for staff. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service. An in-service education programme includes the RNs and external presenters as speakers. Staff also attend DHB study days.</p> <p>The owner/RN has completed her interRAI training. There is a minimum of one first aid trained staff available 24/7.</p> <p>Eleven caregivers and floor assistants work with the residents. Four have completed their dementia qualification. Seven are in the process of completing their dementia qualification. Only one of these seven has been employed for over 18 months. All staff have received regular in-service training and updates around challenging behaviours and caring for residents with dementia.</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>A staffing policy is in place. The roster reviewed was for the care of 27 residents and three day care residents who were present during the audit. Although the facility is contracted for up to 10 day care residents, the facility manager stated that they would not accept more than five with their current staffing.</p> <p>Sufficient staff are rostered to manage the care requirements of the residents. There are two full-time RNs (owner/manager and facility manager with on-site cover provided Monday – Friday and occasional weekends. An RN is rostered on-call when not available on site.</p> <p>AM: There are two long shift caregivers (eight hours) and one (short shift floor assistant (0400 – 0930). The PM shift is staffed with two long shift caregivers and one (short shift floor assistant (1530 – 1830). The night shift is staffed with one caregiver with a second assistant on site on a sleepover shift.</p> <p>The activities staff is employed six days a week from 1030 – 1700. One cleaner is employed five days a week (laundry services are outsourced).</p> <p>Extra staffing hours can be rostered for increased resident requirements as was noted during a recent new</p>

		admission. Staff reported that staffing levels and the skill mix were appropriate and safe. Families interviewed advised that they felt there was sufficient staff available.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurse's station and with individual password protection for electronic data. Entries in hard copy records are legible, dated and signed by the relevant caregiver or registered nurse. Individual resident files demonstrated service integration. Medication records are held electronically on Medimap. All electronic data is backed-up via cloud-based technology.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents are assessed prior to entry by the needs assessment coordination service (NASC) and their level of care is established. The owner/manager and facility manager liaise closely with the assessment team to ensure Dominion Home can meet the prospective resident's needs. Relatives/EPOA receive an information pack outlining services able to be provided, the admission process and entry to the service. Family members interviewed stated that they received sufficient information on the services provided and are appreciative of the staff support during the admission process. Admission agreements reviewed in six resident files sampled (one LTS-CHC, one respite, four ARCC) aligned with the ARRC. Exclusions from the service are included in the admission agreement and the information provided at entry includes examples of how services can be accessed that were not included in the agreement. All admission agreements had been signed in a timely manner.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer (yellow) aged care envelope. Relatives are notified if transfers occur.
Standard 1.3.12:	FA	The medication management system includes policy and procedures that follows recognised standards and guidelines for safe medicine management practice. The registered nurses (owner/manager and facility

<p>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>manager) check medications on delivery against the medication charts. The registered nurses and medication competent caregivers administer medications and they have completed annual medication competencies and education.</p> <p>There were no self-medicating residents. The service does not use standing orders. All medications are stored safely in a locked medication cupboard at the nurses' station. The medication fridge temperature is monitored daily and recorded. The service had no controlled drugs on site.</p> <p>All 12 electronic medication charts reviewed had photo identification and allergies noted. Prescribed medication is signed after being administered as witnessed on the day of the audit. All 'as required' medication prescribed had indications for use documented by the GP. Effectiveness of 'as required' medication administered was documented. All the medication charts had been reviewed three-monthly by the GP.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Dominion Home has a well-equipped kitchen and all baking and meals are cooked on site. There is a full time cook that works from Monday to Friday and a casual cook that covers the weekends. The afternoon meal is prepared by the cook, and the kitchenhand that works from 4 pm – 6 pm heats and serves it. A kitchen service manual is located in the kitchen, which covers all aspects of food preparation, kitchen management, food safety, kitchen cleaning, and kitchen procedures. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. All food is labelled and stored appropriately. All kitchen staff have attended food safety and hygiene, chemical safety and relevant in-service training.</p> <p>A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The cook meets the needs of residents who require special diets. The kitchen staff plate the residents' food from the bain marie in the kitchen and serve in the adjacent dining room. There is special equipment available for residents if required. There is good liaison between the cooks and staff on duty. The cooks follow a three-weekly seasonal menu, which is reviewed by a dietitian annually. Nutritional snacks are available 24/7 for residents. The cook also leaves a bowl of fruit in the dining room for residents to help themselves.</p> <p>The service has reviewed their nutritional programme, kitchen service and delivery as a follow up on a complaint resulting in changes to the service. The service reviewed the five-week menu plan, compiled a culturally diverse menu with a detailed recipe book that was approved by a dietitian. The kitchen was upgraded to include remodelling of the cupboards, a new layout, and new countertops were installed. The kitchen and dining room area was repainted and decorated in more attractive colours. This contributed to making the environment more conducive to eating. Two meal seating times were commenced to allow all residents sufficient time to eat. The resident seating and table allocation list is available to all care staff and kitchen staff to ensure all residents are catered for. The lists assist staff in identifying which residents require assistance or setup. The kitchenhand working from 4 pm to 8 pm is responsible for serving the evening meals, assisting residents with their meal setup and monitoring resident food and fluid intake during meal times. All staff (kitchen and care staff) received</p>

		training on nutrition, presentation of meals, serving of food, setting tables and monitoring weight loss. The kitchen staff ensure that nutritional snacks are available 24 hours for residents. The kitchen had a successful MPI audit and food hygiene grading. The monthly weight monitoring charts reflected that there were no residents with identified weight loss over the past two months.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The reason for declining service entry to residents is recorded and should this occur, it is communicated to the resident and family (as appropriate). The owner/manager reported that the referring agency would be advised when a resident is declined access to the service.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The information gathered at admission is used to develop care needs and supports to provide best care for the residents. A range of paper-based assessments are completed as well as the interRAI assessments. Assessments included (but are not limited to); nutritional assessment, continence, and abbey pain. Risk assessment tools are reviewed at least three-monthly. InterRAI assessments have been completed for all six long-term residents. The outcomes of interRAI assessments including the risk assessments were reflected in the long-term care plans reviewed. The activity coordinator completes a comprehensive social assessment and comprehensive activity care plan in consultation with the family and whenever possible with the resident.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The five long-term care plans were developed by the registered nurse in consultation with the family/EPOA, resident if possible and care staff. The long-term care plans are based on the outcomes of interRAI assessments and other relevant paper-based assessments (eg, three-day continence assessment). Short-term care plans are used for short-term needs. The care plans sampled included documented interventions to meet the resident's assessed care needs. The long-term care plans reviewed demonstrated allied health input into the resident's care and well-being. The family members interviewed confirmed they are involved in the care planning process.</p> <p>The challenging behaviour care plans all had identified current abilities, level of independence, identified needs and specific behavioural management strategies documented within their care plans. Behaviours that challenge</p>

		<p>have been identified through the assessment process. Twenty-four-hour multidisciplinary care plans described the resident's usual signs of wellness, changes and triggers, warning signs of behavioural changes, interventions and de-escalation techniques (including activities), for the management of challenging behaviours. Behaviour charts and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours.</p> <p>The caregivers and activity coordinator interviewed reported they found the care plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The registered nurse (RN) and caregivers, follow the care plan and report progress against the care plan each shift at handover (witnessed). If external nursing or allied health advice is required, the RN will initiate a referral (eg, to the district nurse, wound care specialist, or the mental health nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a three-day continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>There were no wounds or pressure injuries being treated by the service on the day of the audit. Wound assessment, monitoring and wound management forms are available. The RNs have access to specialist nursing wound care management advice through the district nursing service and the DHB wound nurse specialist.</p> <p>Monitoring charts were sighted for food/fluid, behaviours, monthly weight and vital signs, blood sugar levels, and pain.</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>	CI	<p>A service employs one activities coordinator from 10.30 am to 4 pm six days a week. The activities coordinator is currently completing the diversional therapy course. The activities coordinator is supported by the caregivers, floor aids (floor assistants) and nursing students. The caregivers and floor assistants were observed at various times throughout the day constructively engaging with residents thereby diverting residents from behaviours. There are resources available to staff for activities.</p> <p>Each resident has an individual activities assessment on admission and an individual activities plan is developed for each resident by the diversional therapist in consultation with the registered nurse and EPOA. These are evaluated six monthly at the same time as the long-term care plan. Each resident is free to choose whether they wish to participate in the group or individual activities. Participation is monitored and recorded on the activity log and progress notes.</p> <p>There is a large print activities timetable on the residents' noticeboard. There are a wide variety of activities offered including music, crafts, bingo, gardening, karaoke and church services. On the day of audit residents</p>

		<p>were observed starting the day with exercises, participating in a karaoke session, enjoying a van outing and an afternoon walk in the community (accompanied). Residents who prefer to not be involved in group activities have one-on-one visits for chats, hand massage and music. There are two van outings a week. The activity coordinator has a current first aid certificate. An entertainer visits weekly on a Friday. Special events like birthdays, Easter, Mother's Day and Anzac Day are celebrated. Some residents attend a community dementia group. There is a fortnightly church service on site and church visitors also come in to give Mass.</p> <p>The service has residents and staff of diverse cultures, languages and religions. The activity coordinator has developed a programme based on Te Whare Tapa Whā (Māori Health Model) to focus on the health and wellbeing of their residents through engagement and communication with family and community.</p> <p>The LTS-CHC resident is under the age of 65 and enjoys playing cards, listening to music and watching movies. The diversional therapist takes the younger resident to a monthly art group in the community.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Files sampled demonstrated that the long-term care plans were evaluated at least six-monthly (or earlier if there was a change in health status). Care plan evaluations describe progress to meeting goals. There was at least a three-monthly review by the GP. Overall changes in health status were documented and followed up. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service has updated changes in the long-term care plan.</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>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GP. Referrals and options for care were discussed with the family, as evidenced in medical notes.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</p>	FA	<p>There are policies and procedures in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and</p>

<p>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>		<p>chemicals are stored securely. Laundry and sluice rooms are locked when not in use. The laundry service is provided by an external provider. Product use information is available. Protective equipment including gloves, aprons, and goggles are available for use by staff. Staff interviewed were familiar with accepted waste management principles and practices.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility displays a current building warrant of fitness, which expires on 29 September 2020. A maintenance person is employed for five hours a week and is available on-call after hours and on weekends. There is a scheduled 52-week preventative and reactive maintenance plan in place. Contractors are contacted when required. Hot water temperature checks are conducted monthly. Hot water is provided at up to 45 degrees Celsius maximum in resident areas. Medical equipment has been checked and calibrated and testing and tagging of electrical equipment has been conducted (10 July 2019).</p> <p>Residents were observed safely mobilising throughout the facility. The residents can access secure outdoor areas. There is easy access from the central lounge to the outdoor patio. The external courtyards and gardens are well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with the registered nurse and the caregivers confirmed that there was adequate equipment to carry out the cares according to the residents' care plans.</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>All residents' bedrooms have a hand basin. There are adequate communal showers (four) and six communal toilets in the facility. The majority of the showers have a small lip for residents to step over, but these have a safety strip highlighting this. There is a flat entry shower as well and this has a shower chair if required. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs. There is a visitor and staff communal toilet available. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. Staff were observed maintaining residents' privacy when undertaking personal cares.</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>All residents' rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Resident bedrooms are personalised.</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>The communal areas include one large lounge and dining area and one quiet sensory room. There are several smaller seating alcoves where residents can rest. The communal areas are large enough to cater for activities and these were observed taking place. The main dining room is located directly off the kitchen/servery area. All areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit.</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 is a cleaner employed for 30 hours a week and caregivers assist as required. Staff have access to a range of chemicals, cleaning equipment and protective clothing. The standard of the cleaning is monitored through the internal audit programme. Families interviewed were satisfied with the standard of cleaning in the facility. The cleaning trolley is stored in a locked room when not in use. Safety datasheets are available. All laundry is done off site. There are cleaning policies and procedures in place.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security</p>	<p>FA</p>	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire drills are in place. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>Fire training and security situations are included during the orientation of new staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. There is short-term back-up power for emergency lighting and a generator is</p>

situations.		<p>available on loan from the power company if required.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, toilets and showers. A video security camera system is in place to monitor 18 different areas of the facility.</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 communal and resident bedrooms have external windows with plenty of natural sunlight. Heating throughout the facility is managed through four heat pumps in communal areas and electric panel heaters in the residents' rooms. Windows open for ventilation. Family interviewed stated the environment is comfortable.</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>Dominion Home has an established infection control (IC) programme that is being implemented. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The owner/manager, who is a registered nurse is the designated infection control coordinator with support from the facility manager, GP and staff. Infection control data is collated monthly and reported at staff meetings. Education has been provided for staff on orientation and annually through the infection control coordinator. The staff have infection control updates and attend infection training at the local DHB. The infection control programme has been reviewed annually.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine annually. There have been no outbreaks since the last audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to</p>	FA	<p>There are adequate resources to implement the infection control programme at Dominion Home. The infection control (IC) coordinator has maintained their practice by attending annual infection control updates at the DHB. The infection control coordinator has access to GPs, local laboratory, the infection control nurse specialist and public health departments at the local DHB for advice and an external infection control consultant specialist when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>

implement the infection control programme and meet the needs of the organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. The policies are developed by an external consultant and are reviewed regularly. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The facility is committed to the ongoing education of staff and residents. Education is facilitated by the infection control nurse who has completed training to ensure knowledge of current practice. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Education around infection prevention and control has been provided.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms and short-term care plans are completed for all resident infections.</p> <p>Infections are collated in a monthly register and a monthly report is completed by the infection control coordinator. Infection control data, trends and analysis is discussed at the management and staff meetings.</p>

<p>methods that have been specified in the infection control programme.</p>		<p>The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</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>The service has documented systems in place to ensure the use of restraint is actively minimised. The facility manager/RN is the designated restraint coordinator. Staff interviews and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were no residents with restraints or enablers at the time of the audit.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Seven staff have yet to complete their dementia qualification. They are all enrolled and have completed a selection of the dementia papers. Six of the seven staff have been employed less than 18 months.</p>	<p>One of seven staff who has been employed for over 18 months has not completed their dementia qualification.</p>	<p>Ensure all care staff and floor assistants complete a dementia qualification within 18 months of employment.</p> <p>90 days</p>

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 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>A corrective action plan is completed where opportunities for improvements are identified (eg, complaint received). A corrective action plan has also been implemented to reduce the number or residents' falls and has resulted in a rating of continuous improvement.</p>	<p>The number of resident falls in 2018 was 33. This has reduced to only 13 in 2019 (year to date) with three consecutive months (April, May, and June) where there were no resident falls. There has been only one fall in July, one in September and no falls in August.</p> <p>The facility manager stated that this initiative has required all staff to be very diligent. A range of strategies have been implemented. Examples include reducing hazards in the environment (eg, improved lights, more benches and outdoor furniture); improved medication management (frequent GP reviews on all medications that cause dizziness); improving pain management strategies; addressing the strength and balance of residents through tai chi and targeted physical activity programmes; regular eye appointments for the residents; and making sure the residents have adequate food and drink and are regularly toileted. Residents are encouraged to stay out of their</p>

			rooms during the days and a floor aid is staffed on the AM and PM shifts to monitor the residents in the lounge. A stop and watch programme has been implemented which has also assisted in reducing the number of falls. This programme encourages staff to identify any changes in the resident's behaviours or condition (eg, walking differently, developing a rash, weight change, new pain or change in pain).
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Over the past two years the service has admitted an increased number of residents from diverse cultural backgrounds, predominantly Chinese, Indian and Samoan. This resulted in the activity coordinator and the management recognising the need to provide a culturally diverse activities programme that was resident, family and community focused. The programme was based on the four cornerstones of Māori Health (Te Whare Tapa Whā). The focus was on physical health, spiritual health, family health and mental health. On interview with the activities coordinator, it was clearly evident that management and staff were committed to improve the health and overall wellbeing of their residents with dementia. Survey results post implementation of the new holistic activities programme has shown a positive result in the following categories; satisfaction of activities, family/whānau participation, inter-generation participation, therapy programmes, community participation and communication.</p>	<p>Dominion Home has implemented a dementia-specific activities programme catering for their culturally diverse residents, families and staff that exceeds the standard. The model was based on Te Whare Tapa Whā:</p> <ol style="list-style-type: none"> 1) Physical health and wellbeing were promoted with activities including Tai Chi, therapeutic outings to the local yoga venues, gardens and parks. Fun activities included indoor bowls, balloon tennis and netball. An outdoor netball hoop and secured Astro turf garden was set up. The outdoor activity space floor is made up of a soft-landing brick that reduces impact injuries sustained from falls. 2) Spiritual health focused on quality and uplifting the human spirit through multi-denominational church services, holy communion and music therapy which is part of the weekly activities programme. The facility has set up regular pet therapy sessions with a local pet service. The outdoor garden space has a number of raised planter boxes and vegetable gardens encouraging residents to plant flowers and vegetables. These are used to decorate the dining tables and vegetables for cooking. 3) Family Health included setting up range of activities where family members are involved. This included day to day activities and family celebrations. For residents with spouses in the community, the spouses are invited to spend the day at the facility. Families that are overseas are connected with their loved ones through social media (eg,

			<p>Skype, WeChat).</p> <p>4) Mental health, an integral part of residents with dementia is promoted through gardening, karaoke, art therapy and community therapeutic therapy. Community links include the Chinese community forum, St Luke's and Auckland International cultural festival.</p> <p>The enhanced activities programme has resulted in the more effective management of residents with challenging behaviours. NASC referrals/occupancy has increased over the past nine months. Residents have a shortened adjustment period to the facility with non-English speaking residents settling into the facility with greater ease. There is also less frustration experienced because of language differences as there are more resources available to communicate. Families reported that they feel more involved in the care of their loved one by contributing as volunteers with the activities programme and generally, the activities programme has contributed to a decrease in the number of clinical events (eg, falls, infections).</p>
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End of the report.