

Victoria Care Limited

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 BSI Group New Zealand Ltd, 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: Victoria Care Limited

Premises audited: Victoria Care Limited

Services audited: Dementia care

Dates of audit: Start date: 29 April 2021 End date: 30 April 2021

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 44

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

Victoria Care provides care for up to 50 residents requiring dementia level care across two units. On the day of audit there were 44 residents.

This certification audit was conducted against the relevant 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 relatives, management, staff and the general practitioner.

Since change of ownership May 2021, the management team have completed a comprehensive building refurbishment. This has resulted in excellent feedback from families during interview and through surveys around the improvements to the environment and overall care.

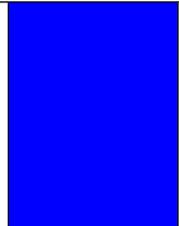
The facility nurse manager (registered nurse) has been in the role since March 2021 and was previously in the unit coordinator role at Victoria. He has experience in leadership and dementia level care and is supported by a unit coordinator (RN). The Victoria Care managers are supported by an organisational management team.

There are well developed systems, processes, policies and procedures that are structured to provide appropriate quality care for residents requiring dementia level care. Implementation is supported through the quality and risk management programme. Ongoing quality initiatives have been implemented at Victoria Care. A comprehensive orientation and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

This certification audit identifies that the service fully met the standards.

The service has been awarded a continuous improvement rating for meeting cultural needs and the activity programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		All standards applicable to this service fully attained with some standards exceeded.
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Information about the services provided is readily available to families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent.

Māori values and beliefs are understood and respected. Care planning accommodates individual choices of residents and/or their family/whānau. Informed consent processes are adhered to. Residents are supported to maintain links with their community.

Complaints processes are implemented, and complaints and concerns are managed appropriately.

Organisational management

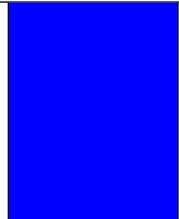
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established and implemented. Annual quality goals are documented for the service and progress reviewed regularly. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Adverse, unplanned and untoward events are documented by staff. The health and safety programme meets current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. The facility nurse manager is supported by a team of RNs. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		All standards applicable to this service fully attained with some standards exceeded.
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There is an admission package available that covers services provided and specific information on the dementia care unit. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident (as appropriate) and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the contracted GP and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior healthcare assistants responsible for administration of medicines complete education and medication competencies. The electronic medicine charts reviewed, met prescribing requirements and were reviewed at least three-monthly.

The activity programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Families reported satisfaction with the activities programme.

All meals and baking are prepared and cooked on site. Residents' food preferences and dietary requirements are identified at admission. Special dietary requirements and dislikes are accommodated. Nutritional snacks are 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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The building has a current warrant of fitness. All rooms are single, personalised and some have ensuite facilities. The environment is secure, warm and comfortable. There is adequate room for residents to wander freely about the home. Communal areas are spacious and well utilised for group and individual activities. The dining and lounge seating placement encourages social interaction. Outdoor areas are safe and accessible and provide seating and shade for residents. There is good indoor/outdoor flow.

There is adequate equipment for the safe delivery of care. All equipment is well maintained and on a planned schedule. All chemicals are stored safely, and the laundry is well equipped. The cleaning service maintains a tidy, clean environment. There is an emergency evacuation procedure. There is a first aid trained staff member on duty at all times.

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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There are policies around restraint minimisation. There were no residents assessed as requiring restraint or enablers. Staff training records evidenced that guidance had been given on restraint minimisation and enabler usage and competencies are completed.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. A unit coordinator/registered nurse is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

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	2	43	0	0	0	0	0
Criteria	2	91	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>Information around the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is in the information pack provided to families during entry to the service. Information is also posted up on walls and in a folder in the entrance foyer. The policy relating to the Code is implemented.</p> <p>The facility nurse manager and care staff interviewed (three RNs including one unit coordinator, four healthcare assistants and one diversional therapist) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through the staff education and training programme.</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</p>	FA	<p>Written informed consent is gained for general consents and were sighted in the seven resident files sampled. Written consent is also gained for specific procedures such as the influenza vaccine. Resuscitation status had been signed appropriately. All seven files reviewed included a needs assessment confirmation for secure dementia level care.</p> <p>Staff interviewed stated the family are involved with the consent of the resident. Enduring power of attorney (EPOA) documents were sighted on the resident's files reviewed. Discussion with family identified the service actively involves them in decisions that affect their relative's lives.</p>

informed consent.		
<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>Health and Disability Commissioner (HDC) advocacy details are included in the information provided to family/whānau during their family members entry to the service. Family interviewed were aware of the role of advocacy services and their right to access support. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</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>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</p> <p>Community links are established with local community groups. Family meetings and newsletters have commenced since change of ownership.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to families during the resident's entry to the service. Access to complaints forms is located at the entrance to the facility. The complaints process is linked to advocacy services.</p> <p>An electronic and paper-based record of complaints received is maintained by the facility nurse manager. There were five (verbal) complaints received and lodged in the register since change of ownership. There have been no formal written complaints. All the five verbal complaints have been managed in accordance with HDC guidelines and response provided to the complainant. All complaints have been discussed in meetings and action plan/training initiated where required.</p> <p>Discussions with families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code and the HDC advocacy service are included in the resident information that is provided to families and EPOA on admission. The facility nurse manager (RN) or area clinical manager discusses aspects of the Code with family on admission. Discussions relating to the Code are also held during the bi-annual relatives' meetings and recent introduced newsletter. All seven family interviewed, reported that the residents' rights were being upheld by the service and this has improved with the change of owner.</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>	FA	<p>The residents' personal belongings are used to decorate their rooms. The healthcare assistants interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas and this was observed on the days of audit. Staff reported that they promote the residents' independence by encouraging them to be as active as possible. Families interviewed and observations during the audit confirmed that the residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect, which begins during their induction to the service. This training is repeated annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>A Māori health policy is documented for the service. Links are established with a local marae. There is a Māori staff member who supports the Māori residents. The Māori staff member attends all related activities to assist residents to maintain Māori protocols including meal set up and saying karakia. The activities staff have met with five Māori residents to identify preferences. As a result, there have been outings to the local marae and regular boil ups and inviting whānau to attend.</p> <p>The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. A care plan reviewed of a Māori resident identified specific cultural considerations have been included. A cultural safety training session has been provided including a cultural quiz.</p> <p>Education on cultural awareness begins during the new employee's induction to the service and continues as an annual training topic.</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>	CI	<p>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all seven care plans reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service.</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>Professional boundaries are described in job descriptions. Interviews with the HCAs and registered nurses confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training, staff meetings, and performance management if there is infringement with the person concerned. Signed house rules and code of conduct is on staff files.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Since change of ownership (30 June 2020), the directors have invested in establishing a strong management team which includes a facility nurse manager (RN) and unit coordinator (RN). They are supported by an experienced area manager (RN) and area clinical manager (RN) across Victoria Care and their sister facility Avon Lifecare. The clinical management team are also supported by a general manager and area care manager.</p> <p>Family/whānau interviewed reported that they are extremely satisfied with the services received. They could not praise the organisation enough for the improvements to the environment, activities and care since change of ownership. This was also confirmed in the recent 2021 family satisfaction survey, with 95% satisfaction nursing/medical, 100% activities and 98% environment. Management continues to focus on upskilling staff. Staff are supported to complete specific dementia training and management of behaviours that challenge. Regularly tool box training sessions are held at handovers.</p> <p>The service receives support from the district health board (DHB). Physiotherapy services are provided as needed.</p> <p>The management team have implemented a range of quality improvements since opening including physical revamp of the environment including provision of Mans shed, kitchenette for residents, other themed sitting areas, completed new nurses' station, new furniture, carpets, paint, new inbuilt furniture in resident rooms, cameras throughout the facility hallways. They continue to expand the activity programme with sensory garden and increased linkages to the community. Have been working on the falls rate with provision of sensor mats, staff education and increased diversional therapy input.</p> <p>Environment changes have enhanced activities involving previous routines for residents with memory loss.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	<p>FA</p>	<p>There is an open disclosure policy; management, registered nurses and care staff interviewed understood open disclosure and providing appropriate information when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Eleven accident/incident forms reviewed reflected documented</p>

communication.		<p>evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. There was one resident at the facility who was unable to speak or understand English. This resident's care plan included comprehensive communication strategies which included a communication book with basic signs and the use of family as interpreters.</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>	FA	<p>Victoria Lifecare provides dementia levels of care for up to 50 residents across two units. There are 24 beds in the Charlotte unit and 26 beds in Elizabeth unit. The DHB has approved the use of all beds in each of the two dementia units.</p> <p>On the day of the audit there were 44 residents. All residents were under the ARCC contract.</p> <p>A philosophy, mission, vision and values are in place. Victoria Lifecare has a robust management structure supported by a documented business operation plan, organisation and resident risk management plan, a quality plan and quality goals. Progress to meeting the 2020 quality goals has been reported on monthly, with two goals carried over into 2021 (activities and education). The 2021 quality goals include (i) improve activities programme, (ii) increase occupancy to 50 beds (this was approved by the DHB March 2021); (iii) increase use of electronic resident management system and (iv) improve healthcare assistant education.</p> <p>Since change of ownership May 2021, the management team have completed a comprehensive building refurbishment. This has resulted in excellent feedback from families around the improvements to the environment and overall care.</p> <p>The facility nurse manager (RN) has been in the role since March 2021 and was previously in the unit coordinator role at Victoria. He has experience in leadership and dementia level care. He is supported by a unit coordinator (RN).</p> <p>There is an area manager (RN), an area clinical manager (RN) and an area care manager. They oversee the management team at Victoria Lifecare and the sister facility Avon Lifecare. Staff interviewed spoke positively about the support/direction provided by management team, they also commented that the service has improved with the current management team. The management team meet weekly which includes the area managers and general manager.</p> <p>The facility manager has maintained over eight hours annually of professional development activities related to managing an aged care service.</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>There is a unit coordinator (with support by the area clinical manager and area manager) who is responsible for clinical operations in the absence of the facility nurse manager. The owner and/or area manager assumes administrative responsibilities in the absence of the facility nurse manager.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The service has an implemented quality system which was purchased from an external consultant. The 2021 quality improvement plan is discussed with staff at the monthly quality meeting and bi-monthly staff meeting. The facility nurse manager reviews progress against goals monthly.</p> <p>Policies and procedures align with current good practice and meet legislative requirements. Policies have been reviewed, modified (where appropriate) and implemented. New policies are discussed with staff.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected for a range of adverse event data (eg, skin tears, falls, infections) and is collated and analysed. An internal audit programme is being implemented. Where improvements are identified, corrective actions (CAPS) are documented, implemented and signed off by the facility nurse manager. Benchmarking occurs with other aged care facilities.</p> <p>Family meetings and newsletters have commenced in 2021.</p> <p>A family survey was last completed March 2021 with a noted improvement on the 2020 survey. Satisfaction was identified as high across all areas including (but not limited to) nursing medical 95%, environment 98% and activities 100%.</p> <p>Monthly quality meetings document comprehensive review and discussion around all areas including hazards, service improvement plans, emergency processes, complaints, incidents and accident, internal audits, infections and a range of clinical outcomes such a weight management, pressure injuries and interRAI as examples. Weekly management meetings allow for teamwork and identification of anything at risk.</p> <p>A risk management plan is in place. Health and safety policies reflect current legislative requirements. Health and safety is a regular topic covered in the quality, staff and management meetings. Orientation includes all aspects of health & safety and bi-annual health & safety training is compulsory through Altura</p>

		<p>training. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. A plan is implemented to orientate contractors to the facility's health and safety programme.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, intentional rounding with two-hourly checks, and challenging behaviour plans.</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>	FA	<p>There is an adverse event management policy that includes definitions and outlines responsibilities including adverse event categories related to risk. Eleven accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurological observations were conducted for suspected head injuries. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service's quality and risk management programme. Monthly adverse event analysis reports are completed.</p> <p>The facility nurse manager is aware of statutory responsibilities in regard to essential notification with examples provided. Two section 31 reports have been sent for a resident absconding. As a result, the facility took actions to prevent this from happening again.</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>	FA	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed (three healthcare assistants, two RNs including the unit coordinator, and one diversional therapist) included evidence of the recruitment process, including reference checking, signed employment contracts and job descriptions, and completed orientation programmes.</p> <p>The orientation programme provides new staff with relevant information for safe work practice that is specific to the job role. Staff interviewed stated that new staff were adequately orientated to the service. A specific orientation training day was provided for all staff following change of ownership in June 2020.</p> <p>Ongoing training is offered to all staff that meets contractual obligations. The service uses a combination of on-line training (Altura), guest speakers, in-service training and additional training is also provided through toolbox talks at staff meetings. Competencies are completed specific to worker type and included at orientation and then annually. These include (but not limited to); H&S, infection control, restraint, moving & handling, medication competency, first aid, and food safety. Registered nurse training and competences include syringe driver, medication and wound care.</p> <p>A register of current practising certificates for health professionals is maintained. There is a Careerforce assessor at their sister site (Avon Lifecare) and one in training at Victoria. There is a total of 19 HCAs.</p>

		<p>Of those 19 HCAs, 13 have completed the required dementia standards, four are in process and two newer staff are yet to start.</p> <p>All three RNs, including the facility nurse manager, have completed their interRAI training.</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>The staffing policy aligns with contractual requirements. The facility nurse manager/RN is on site five days a week and the unit coordinator two days a week. They share on-call when not on site. The area clinical manager and area manager (both RNs) are on site regularly during the week.</p> <p>There are two secure dementia units.</p> <p>Elizabeth Unit (22 residents)</p> <p>A registered nurse is rostered seven days a week 0645 – 1515.</p> <p>There are two x HCAs 0700 – 1515, two HCAs (1500 – 2315 and 1500 – 2300) and one HCA 2300 – 0700 and a floater HCA 2300 – 0700 who moves between the two units.</p> <p>Charlotte unit (22 residents).</p> <p>A registered nurse is rostered seven days a week 0645 – 1515.</p> <p>There are two x HCAs 0700 – 1515, two HCAs (1500 – 2315 and 1500 – 2300) and one HCA 2300 – 0700 and a floater HCA 2300 – 0700 who moves between the two units.</p> <p>AM; one RN and six HCAs (three long and three short shifts). PM; one RN and five HCAs (three long and two short shifts). Night; one RN and two HCAs.</p> <p>There is an activities person and two diversional therapists. Between them, activities staff are rostered over seven days a week and cover sundowning time.</p> <p>Interviews with families and staff confirmed there was good staffing overall.</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 residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Archived records are secure in a separate locked area.</p> <p>Residents' files demonstrated service integration. Entries were legible, dated, timed and signed by the relevant healthcare assistant or RN, including designation.</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>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs for dementia service are provided for families prior to admission. The information pack for dementia level of care contains relevant information relating to a secure unit. Admission agreements were reviewed and aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. Admission agreements for long-term residents had been signed within the required timeframe.</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>Planned exits, discharges or transfers are coordinated in collaboration with the family and EPOA to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medications were stored safely in a newly refurbished medication room. Clinical staff who administer medications (RNs and senior healthcare assistants) have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The RN checks incoming medication blister packs against the electronic medication chart. A medication verification form is signed when the packs have been checked. All medications sighted were within the expiry dates. Eyedrops and sprays were dated on opening. Medication fridge and room temperatures were monitored and recorded daily. Standing orders are not used and no residents self-medicate. The electronic medication charts included the best way to administer medications, (eg, off a tea spoon or with yoghurt). The effectiveness of as needed medication was documented well and the service documents minimal use of sedation and antipsychotic medication.</p> <p>All GP prescribing meets legislative requirements. The GP has reviewed the electronic medication charts three-monthly. There were photographs, and allergy status identified on the medication charts.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are</p>	FA	<p>The service employs cooks and kitchenhands to prepare and cook all meals on site. There is a summer and winter menu that has been reviewed by a registered dietitian (November 2019) who also provides dietetic input around the provision of special menus and diets where required. The cook receives a resident dietary assessment completed by the RN for all residents and is notified of any dietary changes</p>

<p>met where this service is a component of service delivery.</p>		<p>or weight loss. The residents' individual food, fluids and nutritional needs are met. The cook stated that fresh vegetables are purchased weekly. Dislikes, food allergies and cultural requirements are accommodated. Meals are plated in the kitchen and are delivered to the two dementia unit serveries in hot boxes. Specialised utensils and lip plates are available to assist residents with independence at mealtimes. There were nutritional snacks available for residents at any time. Staff were observed to be assisting residents with food and fluids at mealtimes.</p> <p>The chiller, fridge and freezer temperatures are taken and recorded daily. End-cooked food temperatures and serving temperatures are taken and recorded at each meal. The kitchen was observed to be clean, and all aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines with the Food Control Plan (verified until November 2021).</p> <p>Feedback on satisfaction with meals is obtained from residents through resident meetings. The family survey completed March 2021 identified a 94% outcome. The relatives interviewed were satisfied with the meals offered stating the service had improved over recent months.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was 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>The RN completes an initial assessment (in the electronic resident management system) on admission, including applicable risk assessment tools. Behaviour assessments had been completed as needed. An interRAI assessment is undertaken within 21 days of admission, six-monthly, or earlier due to significant changes in health. Resident needs and supports are identified through the ongoing assessment process in consultation with the family and significant others. The long-term care plans in place reflected the outcome of the assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p>	<p>FA</p>	<p>Seven resident files were reviewed for this audit, including a resident with a urinary tract infection, a resident who tended to wander, a resident who has absconded, a resident with falls, a resident with a wound, a resident whose first language was not English, and a younger person (like in age and interest).</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>All of the care plans reflected the assessed needs of the residents and had been personalised following discussion with family, HCAs and allied health services. It was noted that the secure garden had been adapted to ensure the resident who had previously scaled the fence was no longer able to do so. Behaviour management plans were in place for dementia care residents with de-escalation strategies including a 24-hour activity plan that identifies the resident's pattern of behaviour (over the 24 hours). Relatives interviewed confirmed they were notified of an upcoming MDT review and were involved in the care planning process. There was evidence of allied health care professionals involved in the care of the resident including the GP, physiotherapist, dietitian, community mental health services and social worker.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>When a resident's condition alters, the registered nurse initiates a nurse specialist review and if required a GP consultation. There was evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the resident family/whānau contact sheet held in the resident file.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for one resident with a wound. There were no pressure injuries. There was pressure injury prevention equipment readily available to minimise pressure injuries.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain, re-positioning, neurological observations food and fluid intake, bowel monitoring and behaviours of concern.</p> <p>Long-term care plans are updated for any changes to health.</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</p>	<p>CI</p>	<p>The service employs a full-time diversional therapist/manager who leads a team of two further diversional therapists and two activity staff. Between them they provide activities over seven days a week until 1930 in the evening.</p> <p>The programme is planned a month in advance and reflects the cognitive and physical abilities of the groups of residents. Healthcare assistants support residents to attend activities of their choice within their unit or to integrated activities such as musical performers, happy hours and church services.</p>

<p>the service.</p>		<p>The programme reflects meaningful activities such as (but not limited to); men’s shed, ladies beauty club, crafts, exercises, doll therapy, household chores, sorting, supervised ironing, vegetable garden, music and dancing, happy hour and church services. Kindergarten children and school children visit and there are also van outings.</p> <p>Community visitors to the service include entertainers, speakers, pre-school children, churches, hospital chaplain and canine friends. Festivities and themes are celebrated.</p> <p>An activity assessment and activity plan are completed on admission in consultation with the resident/family as appropriate, including a 24-hour daily activity plan. Activity plans in all files were evaluated six-monthly at the same time as the care plan at the MDT meetings with the resident/relative.</p> <p>Families are able to provide feedback and suggestions for the programme through meetings, surveys and one-on-one feedback. Families interviewed on the day of audit commented positively on the activity programme.</p> <p>The service has been awarded a continuous improvement for activities.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plans have been evaluated at least six monthly or earlier for any health changes against the resident goals or transfer to higher level of care within the facility. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and are evident in changes made to care plans. Family are invited to the MDT meetings and if unable to attend are informed of changes to the care plan as documented in the family contact sheet. Written evaluations document if the resident goals have been met or unmet. The care staff are asked for input into the evaluation of the care plan. The RN, DT, physiotherapist, resident/relative and other health professionals involved in the care of the resident are involved in the MDT meeting as needed.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Residents requiring a higher level of care are referred to the needs assessment service for re-assessment as required.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>

choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturers' labels. There is a main chemical storage shed which is locked when not in use. Safety datasheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. Gloves, aprons, and goggles are available for staff. There are two secure sluice rooms; one in each wing and one includes a sanitiser.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current warrant of fitness which expires 1 July 2021. There is a maintenance person on site who works across two sites for 40 hours a week. Requests for maintenance and repairs are written into a logbook which is signed off when repairs are complete. There are essential contractors available 24-hours. The maintenance person completes a monthly facility check which includes monitoring hot water temperatures in resident toilets/showers. Water temperatures were within range. Testing and tagging of electrical equipment and calibration of clinical equipment has been completed.</p> <p>All corridors are wide enough to promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The secure external areas and gardens are well-maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.</p> <p>There is a large secure outdoor garden and walking pathway off the dementia care unit. Seating and shade are provided and there is natural shade provided by trees in the grounds. Residents have easy access to secure garden areas. Some trees have been trimmed following a resident climbing a tree to leave the unit. There are pathways in the gardens that link round in and out of the wings to allow residents to wander around easily.</p> <p>Healthcare assistants stated they had sufficient equipment to safely deliver cares as outlined in the resident care plans. There is a hoist available for use for falls. New equipment had been purchased to replace older equipment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p>	FA	<p>There are toilets close to the large communal lounges and near the smaller sitting lounges. All communal toilets and bathrooms are well signed and have privacy locks. All communal bathrooms allow for mobility equipment. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are</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.		constructed for ease of cleaning. Communal, visitor and staff toilets are available and contain flowing soap and paper towels. The majority of communal bathrooms have been renovated.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All rooms are single. There is sufficient space in the comfortably sized rooms, with space for furniture as well as equipment needed to provide care. Resident rooms have been refurbished as they have been made available.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Each wing has a large open plan lounge and dining room at one end. There are separate smaller seating lounge areas with doors that open out onto the gardens with seating and shade. The large lounge allows for group activities and areas for relaxation and quiet areas. The large communal area has locked partitioned doors to the neighbouring dementia unit lounge. This could be opened if needed for shared entertainment.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is undertaken on site. The laundry is divided into a 'dirty' and 'clean' area. There are two doors into the laundry, one entrance and one exit. Both doors are secure. Healthcare assistants are responsible for laundry. A cleaning schedule is maintained, and the service was clean and well maintained. There is a cleaner rostered in each unit daily. There is personal protective equipment readily available. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. There are laundry and cleaning procedures available. Cleaning and laundry services are monitored through the internal auditing system and externally by the chemical provider.
Standard 1.4.7: Essential,	FA	There are emergency policies and procedures in place. There is an approved fire evacuation plan.

<p>Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>Evacuation drills occur at least six-monthly. There is a staff member on duty 24/7 with a current first aid certificate.</p> <p>In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare batteries for lights, a gas barbecue, linen, continence products, torches and batteries, water and blankets. There is a generator available. Food dry stock and frozen food are available to support residents for at least three days. There is sufficient stored water in tanks.</p> <p>The call bell system has been upgraded and available in all resident rooms, communal areas and toilet/shower facilities.</p> <p>The entrance to the dementia unit is secured with keypad entry. A perimeter fence around both dementia units with locked gates ensures residents are kept safe. Staff on the afternoon and night shifts are responsible for ensuring the facilities doors and windows are closed appropriately and doors are locked appropriately.</p> <p>External doors are locked in the evening. There are cameras positioned on outdoor areas. The RNs have a mobile phone, there is external lighting.</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 bedrooms and communal areas have natural light and ventilation. Lighting is increased for the needs of this resident group. All has been upgraded since the previous audit. Heating is now provided via ceiling heaters. Each rooms heating can be individually controlled. There are opening windows in resident bedrooms and doors that open to the outdoors in communal areas.</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>Victoria Care has an established infection control programme. The infection control programme has been reviewed for 2020. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the infection control coordinator. The infection control coordinator has support from all staff including the GP. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.</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>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team have good external support from the GP and clinical specialists at the DHB. Infection prevention and control is part of staff orientation. Hand washing facilities are available throughout the facility and hand sanitiser is freely available. The service has a designated IC room which includes outbreak kits.</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>Victoria Care has infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff and has completed DHB training in infection control. Infection control education has been provided in the past year. Staff receive education on orientation and one-on-one training as required.</p> <p>Information is provided to residents and visitors that is appropriate to their needs. Resident education occurs during care and as needed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected and reported monthly by unit for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at monthly meetings. If there is an emergent issue, it is</p>

<p>methods that have been specified in the infection control programme.</p>		<p>acted upon in a timely manner. Reports are easily accessible to the facility nurse manager. Overall infection rates are low. The service locked down during March 2020 as six residents had 'runny noses'. The symptoms did not comply with any infection criteria, however the service decided to implement infection control isolation as a precaution and the issue was resolved.</p> <p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility.</p> <p>There are policies and procedures in place around Covid-19. Staff have received additional training around PPE, hand washing and standard precautions. The service has sufficient PPE available for staff. All new residents are screened prior to service entry as evidenced on one resident file during the audit.</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 around restraint minimisation. There were no residents assessed as requiring restraint or enablers. Staff training records evidenced that guidance had been given on restraint minimisation and enabler usage and competencies are completed. Staff have also been trained in behaviour management and de-escalation techniques.</p> <p>Staff receive training on restraint minimisation and managing behaviours that challenge. The healthcare assistants interviewed were able to describe the difference between an enabler and a restraint.</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 1.1.6.2</p> <p>The consumer and when appropriate and requested by the consumer the family/whānau of choice or other representatives, are consulted on their individual values and beliefs.</p>	CI	<p>The achievement of the rating that the service provides an environment that encourages good communication and activities around individual culture/values/beliefs is beyond the expected full attainment. Example: A cultural quality project was implemented following feedback from residents that identified as Māori. One on one talks with Māori residents raised concerns with lack of opportunity to connect with iwi. There are also two non-speaking English Chinese residents and there were</p>	<p>As part of the cultural quality improvement project they implemented a number of initiatives to support different cultures by identifying preferences and how best the service could meet them. The diversional therapy/activities team and care staff met with five Māori residents to identify preferences. As a result, they implemented outings to the local marae, regular boil ups and inviting whānau to attend. There has been increased encouragement of staff to use te reo Māori in general conversation. Set up a cultural resource folder including language, iwi information on each Māori resident. Māori staff member attends all related activities to assist residents to maintain Māori protocols including meal set up and karakia. For the Chinese residents the service set up Chinese que cards, implemented use of a language conversion software application - google translate. Set up information in cultural resource folder on Chinese customs and traditions, celebration of Chinese New Year, and outings to Chinese market at Church corner. The service has evaluating these initiatives in a number of ways. The survey results show improvement with specific comments re cultural satisfaction. There was increased use of te reo Māori in general conversation. Staff education – Altura and Toolbox talk on cultures and individual associations, diversity and aging occurred and there was excellent family</p>

		difficulties around communication with those Chinese residents.	feedback and appreciation.
<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>The service identified at purchase of the service that the activities programme was an area for improvement. In discussion with staff and families it was identified that, the incidence of behaviours that challenge was high, the level of activity staff and activity resources needed improving. A plan was implemented to improve the activities for residents at Victoria Care.</p>	<p>The service employed additional full time activity staff including two qualified diversional therapists and two activities coordinators with two staff rostered eight hours a day, seven days a week across different time slots. The service ensures activities staff presence in each wing from 1630 till 1930 to assist with encouraging good nutritional input and distraction as required. The activity programme was updated to include large group activities three times a day and at least two to three hours a day scheduled for one-on-one resident care. Additional activity resources were purchased as recommended by a qualified diversional therapist, HCAs and family input. Additional resources purchased included a sorting trolley, kitchen equipment, shed tools, nails, paint brushes etc., dart board, items for reminiscing, craft activity items, board games, sports equipment, jigsaws, foot spa, beauty equipment nail polish etc. children's clothing for folding, clothes line, and vegetable garden. Staff education was provided around cultural care and integrating activities as part of daily care.</p> <p>As a result of this ongoing project, there has been a decrease in challenging behaviour and as needed antipsychotic medication in six specific long-term residents. There has been an improvement in family satisfaction from 77% satisfied to 100% of respondents were happy with the activities programme. Monthly management and activity staff meetings have ensured that the project has been evaluated and improved over time.</p>

End of the report.