

Graceful Home Shoal Bay Limited - Shoal Bay Dementia

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 HealthShare 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: Graceful Home Shoal Bay Limited

Premises audited: Shoal Bay Dementia

Services audited: Dementia care

Dates of audit: Start date: 30 August 2018 End date: 31 August 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 23

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Shoal Bay Dementia can provide care for up to 26 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. A change in ownership occurred on the 1 November 2017 after approval by HealthCERT following the provisional audit.

The audit process included the review of policies, procedures and residents and staff files; observations; interviews with family, management, staff, a pharmacist and a medical officer.

Improvements are required to the following: advance directives; the orientation and training programme including training around dementia; staff with training on dementia on each shift; quality and risk management; documentation of 24-hour activity plans for each resident; review of the menu and registration of food services as per the Food Act.

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.		Some standards applicable to this service partially attained and of low risk.
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Residents receive services in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The systems protect their privacy and promote their independence. There is a documented Maori health plan in place which acknowledges the principles of the Treaty of Waitangi. Individual care plans include reference to residents' values and beliefs.

Management and staff communicate openly with residents (as able) and relatives are kept up-to-date when changes occur. Systems are in place to ensure residents are provided with appropriate information in a way they can understand to assist them to make informed choices and give informed consent.

The rights of residents or their legal representatives to make a consumer complaint is understood, respected and upheld. An up-to-date complaints register can be maintained noting that there have not been any complaints since the new ownership. Consents are documented by residents.

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 medium or high risk and/or unattained and of low risk.
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The philosophy of the service and a business risk management plan are documented. The service is managed by the director/manager and they are supported by a personal assistant on site and a registered nurse who provides clinical oversight.

There is an established quality and risk management system. There are a range of policies and associated procedures and forms in use to guide practice. Data is collected with information discussed through staff meetings. Adverse events are discussed and reported to management.

There is a clearly documented rationale for determining staff levels and staff mix in order to provide safe service delivery. The service has increased staffing levels on the morning and afternoon shifts with the registered nurse and team leaders providing support for staff. Staff are knowledgeable and skilled.

Resident information is stored securely.

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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Assessments and care plans are completed and evaluated by the nursing team within the required time frames. Activities plans are completed by the diversional therapist (DT) and planned activities are appropriate to the resident's assessed needs and abilities. In interviews, family/whanau expressed satisfaction with the activities programme in place.

Medications are managed and administered in line with the sighted medication management policy and meet legislative requirements. Medications are monitored and reviewed as required by the general practitioner (GP). The organisation uses an electronic system in e-prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for. Snacks and drinks are available 24 hours for residents if needed.

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 and New Zealand Fire Service evacuation scheme in place. A preventative and reactive maintenance programme includes equipment and electrical checks.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. The dementia service is secure. Outdoor areas are available for residents.

Essential emergency and security systems are in place with regular emergency drills and staff training completed.

A refurbishment programme is underway.

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 clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in the management of challenging behaviours.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection control management systems are in place to minimise the risk of infection to residents, visitors and other service providers. The infection control coordinators are responsible for co-ordinating education and training of staff. Infection control education is provided as part of orientation and on-going educational programme. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	38	0	3	4	0	0
Criteria	0	85	0	3	5	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>Policies and procedures are in place to ensure resident rights are respected by staff. Staff receive education during orientation and ongoing training on resident rights is included in the staff annual training schedule. Staff have had training around rights and advocacy in 2018.</p> <p>Staff interviewed are all able to articulate knowledge of the Health and Disability Commissioner's Health and Disability Services Consumers' Rights (the Code) and how to apply this as part of their everyday practice. Staff interviewed confirm they receive ongoing education on the Code.</p> <p>Visual observations during the audit and the review of clinical records and other documentation indicate that staff are respectful of residents and incorporate the principles of the Code into their practice. The service provides information on the Code to families and residents on admission.</p> <p>Residents and family interviewed state that they receive services as per the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided</p>	PA Low	<p>There is an informed consent policy in place. Consent is included in the admission agreement and sought for appropriate events. Staff mostly use verbal consents as part of daily service provision. Staff demonstrate an understanding of informed consent processes.</p>

<p>with the information they need to make informed choices and give informed consent.</p>		<p>Residents and relatives confirm that consent issues are discussed with the relatives and residents on admission. All residents' files reviewed include documented written consent.</p> <p>There is a policy that reflects evidence and best practice around advanced directives. There is a requirement to ensure that practice reflects the policy.</p>
<p>Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Information on advocacy services is available in the service.</p> <p>Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.</p> <p>Discussions with family identifies that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident's family and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are no set visiting hours and family report that they are encouraged to visit at any time. Family were observed to visit the service during audit days.</p> <p>Family confirm that residents are supported and encouraged to access community services or as part of the planned activities programme and through family outings. The service encourages the community and family to be a part of the residents' lives.</p> <p>Family interviewed state that they are provided with information on entry around the philosophy and practices of the service; the way in which the facility is kept safe and secure and rationale for this; how challenging behaviours are managed; the complaints process. The welcome pack includes a description of the service and this describes the key aspects of the dementia service.</p>
<p>Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints.</p> <p>Complaints management is explained as part of the admission process with the policy and forms included in the information pack given to potential residents and family. Family confirm that the management open door policy makes it easy to discuss concerns at any time.</p>

		<p>Training around the complaints policy and process is part of the staff orientation programme and ongoing education.</p> <p>The complaints register can record the complaint, dates and actions taken. There have not been any complaints since the new ownership commenced.</p> <p>The director/manager confirms that there have been no complaints from external authorities since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information on the Code and the Nationwide Health and Disability Advocacy Service are displayed in the facility. There is a poster of the Code in each bedroom and this references the Nationwide Advocacy Service. Family confirm that they know where to find information. Information around the Code and advocacy services and the Code is included in the admission information pack and described by the director/manager as being discussed with residents and relatives on admission.</p> <p>Residents and relatives interviewed confirm that the Code, the advocacy service, and residents' rights are explained on admission. They also state that they can discuss any concerns with the director/manager and other staff particularly the senior staff at any time.</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>There are a range of policies and procedures in place to ensure residents are treated with respect.</p> <p>Staff endeavour to maximise residents' independence by encouraging residents to actively engage in cares and to continue to access the community as long as possible. There is respect for residents' spiritual, cultural and other personal needs as confirmed by residents and family interviewed. Residents are referred to by their preferred name as observed on the day of audit.</p> <p>Residents and relatives interviewed state that staff have regard for the dignity, privacy, and independence of residents. There are quiet, low stimulus areas that provide privacy for residents in the dementia unit. Staff describe how they treat residents and family with respect and dignity.</p> <p>There is no evidence of abuse or neglect. Policies and procedures are explained by staff with a description of how they would escalate any issues of abuse or neglect if these were identified. Procedures described are in line with the policy. Staff, the pharmacist interviewed, family members and the general practitioner interviewed confirm that there is no evidence of abuse or neglect. A review of incidents for the last year did not indicate that any abuse or neglect had</p>

		occurred.
<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>There are policies and procedures covering cultural safety and cultural responsiveness. The documentation includes appropriate Māori protocols and provides guidelines for staff in care provision for Maori residents. The documentation is referenced to the Treaty of Waitangi.</p> <p>Staff interviewed confirm an understanding of cultural safety in relation to care. Cultural safety education is provided in the orientation programme and thereafter through refresher training.</p> <p>On the days of audit there were resident/s who identified as Māori and staff interviewed described how they had asked family, about the care they should and could provide for the resident. In a resident file reviewed, there is specific assessment related to Māori cultural needs with a relevant plan included.</p> <p>Access to Māori support and advocacy services are available if required. Systems are in place to allow for review processes including input from family/whanau as appropriate, for residents who identify as Māori.</p> <p>The director/manager identifies as Māori, speaks te reo and has extensive links with Māori services if required. Other staff when on duty can speak te reo. Care staff interviewed were able to describe strategies to meet needs of Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>There are policies and procedures in place to guide staff on cultural safety and cultural responsiveness. Cultural preferences are included in the assessment process on admission and individual values and beliefs are then documented in the care plan.</p> <p>There are spiritual services weekly with different denominations rostered over a monthly period.</p> <p>Staff interviewed confirm their understanding of cultural safety in relation to care.</p> <p>Family members interviewed confirm that values and beliefs are respected by staff.</p> <p>Some staff when on duty communicate to residents who have languages other than English as their first language. Staff are also able to describe differences for people who identify as being from other countries.</p>
<p>Standard 1.1.7: Discrimination</p>	FA	<p>There are policies and procedures in place to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is</p>

<p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>		<p>inappropriate or unlawful conduct. Expected staff practice is outlined in job descriptions.</p> <p>Staff demonstrated an awareness of the importance of maintaining boundaries with residents. Residents and relatives reported that staff maintain appropriate professional boundaries, including the boundaries of the health care assistant role and responsibilities. Family confirm that staff keep professional boundaries.</p> <p>The director/manager and staff are very aware of the need to ensure that the residents in the facility are supported and not taken advantage of in any way. Examples were able to be given with strategies to address if this occurred.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are policies and procedures to guide practice. These align with the health and disability services standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external consultant. Evidence based guidelines, treatment protocols, reference material and resources are available and utilised by staff. Staff have access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice.</p> <p>The education programme is documented (refer 1.2.7) and staff can access health professionals from the District Health Board as required.</p> <p>Family members interviewed confirm they are very happy and satisfied with the care provided to their relatives living in the dementia unit. They state that they have noticed significant improvement in the service since the change in ownership. This has included refurbishment; an increase in staffing; open communication with a transparency of any issues; improved spaces to be with their family member; consistently high level of satisfaction with food services.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The service provider has policies covering communication, access to interpreters and maintains an open-door policy. Information is provided in a manner that the resident can understand. Relatives state that they can discuss issues at any time with staff. The incident and accident forms include an area to document if the relatives have been contacted and a record of communication with family members is retained in each resident file. Open disclosure is practised and documented when family are contacted.</p> <p>Relatives interviewed confirm that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirm that they are advised if there is a change in their family member's health status. The general practitioner interviewed reported satisfaction</p>

		<p>with communication from staff.</p> <p>There is a policy around use of interpreters and access to interpreting services is documented. One resident speaks very little English. Staff use phrases documented by family and an app on their phone that verbally gives the phrase and translation. Staff interviewed have learnt phrases in the resident's language and were able to demonstrate their proficiency on the audit day. Staff also state that family can interpret as necessary. Residents in the unit do not always communicate well verbally and staff describe looking at body language and using other ways of identifying resident needs. This includes asking family about the resident and to tell them if there are cues they are missing. Staff also describe using simple language and giving simple choices for residents who have dementia or who find communication difficult.</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>Shoal Bay Villa Rest Home was purchased by Graceful Home No.2 Limited on the 1 November 2017. There is an organisational structure, with the director being supported by a business partner (accountant) who provides financial support. The director also owns a home care service; a rest home since February 2014 and a dementia unit in close proximity. The director is the manager (director/manager) of the service and provides oversight and leadership.</p> <p>The business has agreements in place with Waitemata District Health Board for the provision of aged residential care at rest home – dementia level of care. Of the 26 beds identified as being certified, 23 were occupied on the days of audit.</p> <p>The philosophy is documented and displayed for residents and families. The business plan includes goals. A process for review should be established. The business risk management plan is documented and the director/manager states that they review this with the business partner annually. Review is not required at this point.</p> <p>The director/manager has completed training relevant to the role in management and is supported by a registered nurse who has two years' experience working in a rest home/hospital service. The registered nurse has attended a three-day training course around implementing the Eden Alternative in Aged Care but has limited experience in dementia care and has not had training in dementia (refer 1.2.7). The registered nurse has completed at least eight hours of education in the last year to maintain their practising certificate.</p>
Standard 1.2.2: Service Management	FA	<p>During the temporary absence of the director/manager, the personal assistant would provide operational oversight. They have completed management training and have experience as a</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>manager in other facilities. The director/manager states that they would be available by phone at any time.</p> <p>There are registered nurses in the two other facilities owned by the director/manager. They would be designated as being available to provide clinical oversight if the registered nurse was unable to perform the role when on leave. One registered nurse at another facility has already gained sound knowledge of the residents and systems at the service as they are responsible for working with the registered nurse to complete the interRAI assessments.</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>PA Moderate</p>	<p>The quality and risk management programme identifies objectives for the service. The service uses an external quality and risk management consultant to provide advice on policies, procedures and forms. Policies sighted reflect current good practice, legislation and compliance requirements with policies current (last reviewed in 2018) with reference to new legislation documented. All documents sampled are controlled and obsolete documents removed from circulation. Policies and procedures and the internal audit schedule include reference to interRAI and care planning processes.</p> <p>Aspects of the quality programme are linked into the six-weekly staff meeting (noting that this should be held as scheduled at set intervals). These include discussion around complaints, incidents, infections and clinical issues. There is evidence discussion of graphs with an example of falls being analysed as a result of data being presented around number, site of the fall and time of the fall. Results from January 2018 to August 2018 show a dramatic decrease in falls with this attributed to strategies put in place including the increase of staff on the morning and afternoon shifts, purchase and use of sensor mats, use of hip and other protectors and an increase in training for staff around management of falls.</p> <p>The internal audit schedule is documented annually, and internal audits are completed as per the schedule. Reporting of results should be documented as being completed through meeting minutes. Corrective action plans are documented. There is some evidence of documentation of resolution of issues however an improvement is required.</p> <p>There is a process planned to measure achievement against the quality and risk management plan noting that review has not been required to date.</p> <p>The service has completed a satisfaction survey last in August 2018 with results being collated. A review of those returned indicates that there is a high level of satisfaction with no issues or concerns identified.</p> <p>A business risk management plan is documented. There is also a hazard register documented. Health and safety systems have been reviewed since the introduction of the Health and Safety</p>

		at Work Act 2015. While health and safety is an agenda item, there is little evidence of discussion through the staff meeting around health and safety and in particular potential and actual hazards and risks. Staff have completed training around health and safety in 2018.
<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>	PA Low	<p>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirms that incidents and accidents are being reported with these reviewed by the registered nurse with escalation to the director/manager if required.</p> <p>The incident forms that have been completed show evidence of immediate responses, investigations and remedial actions being implemented as required. This includes reporting to family members and informing the general practitioner when incidents occur. Both family and the general practitioner interviewed confirm that incidents are reported in a timely manner. Monthly statistics on all documented adverse events are collated, analysed and reported at staff meetings.</p> <p>The director/manager understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. The director/manager or delegated has not informed the Ministry of Health (MoH) or the District Health Board formally of the change in manager and registered nurse.</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>	PA Moderate	<p>There is an established system in place for human resource management.</p> <p>All staff records reviewed include an employment agreement and a position description. Staff have criminal vetting prior to appointment noting that the service is waiting on some that are currently being processed. Professional qualifications are validated. All staff receive an orientation and participate in ongoing refresher education. Reference checks are routinely completed and sighted on file for staff who have been employed by the current director/manager. Performance appraisals are expected to be completed annually as per policy for all staff noting that to date these have not been required to be completed.</p> <p>A registered nurse from another facility is interRAI trained and they work alongside the registered nurse to complete resident assessments. There is another registered nurse in the services owned by the director/manager who is able to complete interRAI assessments if required. Medicines are given by the registered nurse and healthcare assistants who have been assessed as competent with competencies sighted during the audit.</p> <p>An orientation programme is documented. There are differences in the orientation programmes</p>

		<p>offered to registered nurses and to health care assistants. The orientation programme does not include training around dementia. Staff files include evidence of completion of orientation.</p> <p>There are six health care assistants who have completed NZQA approved training in dementia (refer 1.2.8). New staff have been employed and have completed orientation. There has not been training to date for staff around dementia and new staff are not yet enrolled in the course (noting that they have 18 months to complete the training from employment date). An annual training plan is not documented however training has been provided in the past eight months including training around falls, documentation, rights and other key topics. The registered nurse has not had training and has limited experience of dementia care.</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>PA Moderate</p>	<p>The process for determining provider levels and skill mix is defined in policy and takes into account the layout of the facility and levels of care provided. Staff rosters are developed by the director/manager in conjunction with the personal assistant. Rosters and staff interviewed and observation on the days of audit confirmed there were sufficient numbers of staff in each area to meet minimum requirements as specified in the Aged Residential Care Agreement.</p> <p>The director/manager has increased staffing since ownership with two additional short shifts in the morning and afternoon now in place. This has significantly improved resident care and has been noted by family members as decreasing falls, having increased supervision and as promoting an increase in the ability to communicate with staff.</p> <p>Casual staff (known by the service) are available to pick up extra shifts when staff rostered are on leave with a review of rosters confirming that staff are replaced if absent.</p> <p>There is a staff member on duty with a current first aid certificate on each shift. The registered nurse is on call with the director/manager able to be contacted at any time.</p> <p>There are four health care assistants in the service on the morning and afternoon shifts and two overnight. This includes two staff on a short shift in the morning and afternoon.</p> <p>There are 23 staff employed in the service. There are now two team leaders who are responsible for oversight of the morning and the afternoon shifts when on duty. They also support the registered nurse and the personal assistant (both 40 hours a week) to complete quality improvement activities. There is a cleaner/laundry staff member on duty seven days a week and a chef and cook seven days a week. All other staff are care staff with maintenance completed by a contractor.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Paper-based resident records are maintained for each resident. The resident records are stored in a locked cupboard in the office or stored electronically with appropriate back-up systems in place. The detail is adequate and records information important for ongoing care and support being provided.</p> <p>A record of past and present residents is maintained electronically. InterRAI assessments are completed by a registered nurse from another facility who works alongside the registered nurse and staff in the service. Progress records are clearly documented by care staff in the paper-based record. The date, time, signature and designation of those entering into the records is legible. Resident records are integrated.</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>	<p>FA</p>	<p>Shoal Bay Dementia's welcome pack contains all the information about entry to service. The policy has all the required aspects of management of enquiries and entry. Assessment and entry screening processes are documented and clearly communicated to family/whanau of choice where appropriate, local communities and referral agencies.</p> <p>The entry to service process was conducted within the required time frames and were signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services to be provided.</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>	<p>FA</p>	<p>There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>A documented medicines management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medicine entries sampled complied with the required legislation, protocols and guidelines. Medicines are stored safely and securely in the treatment room, locked cupboards and drug trolley. Medicine reconciliation is conducted by the RN when residents are admitted and when transferred back to the service. The organisation uses pre-packed medicine packets which are checked by the RN on delivery. All medicines are reviewed every three months and as required by the GP. Allergies are clearly indicated, and photos are available to assist with identification.</p>

		An annual medicine competency is completed for all staff administering medicines and training records were sighted. The RN was observed administering medicines correctly. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner.
<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>	PA Low	<p>Meal services are prepared on site and served in the allocated dining rooms. Diets are modified as required and the cook confirmed awareness on dietary needs required by the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night on a 24-hour period. The family/whanau interviewed acknowledged satisfaction with the food service.</p> <p>All food services staff have completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.</p> <p>An improvement is required to ensure the food service is registered under the new food control plan act and menu to be reviewed by the dietitian.</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>	FA	The RN reported that whenever a consumer is declined entry, family/whanau are informed of the reason for this and other options or alternative services available and this is recorded on the new resident enquiry form. The consumer is referred to the referral agency to ensure that the consumer will be admitted to the appropriate service provider.
<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 initial assessments are completed within the required time frames on admission. Care plans and interRAI assessments are completed within three weeks of admission. Assessments and care plans are detailed and are completed in consultation with the family/whanau and other health team members as appropriate. In interviews conducted family/whanau expressed satisfaction with the assessment process in place.

<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>Care plans sampled were resident focussed, integrated and provide continuity of service delivery. Care plans include the required interventions that addresses the outcomes identified by the ongoing assessment process. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. The family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.</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 documented interventions in short term care plans and long-term care plans are sufficient to address the residents' assessed needs and desired goals/outcomes. The individual behaviour management plans in some files sampled, specified prevention-based strategies for minimising episodes of challenging behaviours and described how the residents' behaviours were managed over a 24- hour period. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift.</p> <p>Adequate clinical supplies are available, and the staff confirmed they have access to enough supplies. Family/whanau members interviewed reported satisfaction with the care and support their families/whanau are receiving.</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>	PA Moderate	<p>Residents' activities interest form is completed within two weeks of admission in consultation with the family. The activities are conducted by the qualified diversional therapist who develops the activity plan which is posted on the notice boards. The group programme is varied and appropriate for people with dementia.</p> <p>The residents were observed to be participating in a variety of activities on the audit days. There are planned activities and community connections that are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family/whanau interviewed reported overall satisfaction with the level and variety of activities provided. An improvement is required to ensure all files have a 24-hour activity care plan in place.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are</p>	FA	<p>Residents' long-term care plans, interRAI assessments and activity plans are evaluated at least every six months and updated when there are any changes. Family/whanau and staff are consulted in the review process. The evaluations record how the resident is progressing towards</p>

evaluated in a comprehensive and timely manner.		meeting their goals and responses to interventions. Short term care plans are developed when needed and signed and closed out when the short-term problem has resolved.
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 choice/needs.	FA	There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the GP and RN.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Policies and procedures specify requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances on an annual basis. Chemicals are stored securely and the required personal protective equipment/clothing (PPE) is available. Staff confirm they can access PPE at any time and were observed wearing disposal gloves and aprons when these were required. The health care assistants and cleaner/laundry staff demonstrate knowledge of handling waste and chemicals and were observed to keep the cleaning trolley in sight when in use. Waste is of a domestic-type and is managed via a local council services.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current warrant of fitness. There is a fire evacuation scheme (issued 10 October 2013) from the New Zealand Fire Service. Planned and reactive maintenance is implemented by contractors with oversight from the director. The physical environment internally and externally is maintained to minimise risk of harm, promote safe mobility, aid independence and is appropriate to the needs of the current residents. The electrical equipment was tested and tagged on the day of audit. Medical equipment has

		<p>been provided by the pharmacy who has confirmed that this is all newly purchased.</p> <p>There are outdoor areas available for all residents including verandas and outdoor garden areas. The courtyard area has been renovated to allow for more seating and a circular grassed area that is well used by family and residents.</p> <p>There has been extensive refurbishment to date that has included renovation of a bathrooms, bedrooms, flooring in the lounge, one of the decks and other immediate maintenance issues as these have been identified. There is a planned approach to maintenance and continued refurbishment.</p> <p>One ramp is closed as there are rotten boards. There are other exits for residents to use and the closure does not compromise safety. There is one bathroom that requires some refurbishment however this does not compromise safety for residents and is on the planned refurbishment list as a priority.</p> <p>Exits are controlled by pin codes. Entry for visitors is identified with a bell to contact staff. One exit is only accessible to residents if they are assisted by a staff member of family member. The area has council bins stored and the railing could potentially pose a risk to residents. Residents are only able to exit this way if supervised by staff or family as the railing could potentially be scaled. All staff and family are aware of this and there is a pin code key on the door.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are sufficient toilets, hand basins and showering facilities available for residents. Some bedrooms have a toilet and hand basin. The rest home has communal toilets and showers.</p> <p>There are appropriate privacy protections in place when showers and toilets are in use.</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 have their own room with these personalised with their own belongings.</p> <p>There is ample room for mobility aides to be used safely in each resident's room. Family confirm that there is sufficient space in each room for personal items.</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>There is a large lounge/dining area in the dementia unit. The lounge is also used for activities. There is a smaller area outside of the kitchen which is also used by some residents who like a quieter place to eat. Staff and family state that a number of activities also occur outside in the courtyard.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are separate laundry and linen service manuals available and reviewed containing all relevant cleaning and laundry policies and procedures to guide staff. Staff know how to access the information and can describe implementation as per policy.</p> <p>The service employs a cleaner/laundry assistant seven days a week. All cleaning processes are documented. There is adequate storage for all chemicals in a locked designated area. The cleaner/laundry assistant washes and dries personal items and some communal linen and there is an external provider that washes and dries communal laundry such as sheets and towels. There is dirty and clean separation in the laundry. The cleaner/laundry assistant was able to describe procedures including soaking and washing of soiled and/or infectious linen.</p> <p>There are material data sheets available for all chemical products with a locked cupboard for all chemicals. The director/manager, registered nurse and team leaders monitor the cleaning and laundry service through the internal audit programme and on a day to day basis to ensure resident and relative satisfaction is maintained.</p> <p>Relatives interviewed confirm satisfaction with the cleaning and laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an approved evacuation plan and this is displayed and current. Emergency drills take place at least six-monthly. Training is provided around emergencies and security from a health, safety and reporting perspective annually.</p> <p>In the event of an emergency, alternative energy and utility sources are available such as emergency lighting, and spare battery lights, a gas barbecue, water for drinking, linen, continence products, torches and batteries, water, gas heaters, and a gas stove. Food dry stock and frozen food is available.</p> <p>An electric call bell system is available throughout the service and those randomly trialled were operational on the days of audit.</p> <p>The dementia unit is secured with key pad entry to the service. A perimeter fence is erected and is locked. Staff on the afternoon and night shifts are responsible for ensuring the facilities</p>

		doors and windows are closed appropriately and doors are locked appropriately. The director/manager, person on call or emergency services can be contacted if staff are concerned or if an emergency occurs. Residents have access to outdoor areas within the perimeter area whenever they wish.
<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 have an external window that can be opened for ventilation. The buildings are ventilated by opening windows and doors. There are heaters which keep all rooms warm.</p> <p>There are heat pumps in the 'villa' wing with the rooms noted to be warm on the days of audit. The director/manager has installed a central heating system in all other parts of the facility. All panel heaters, oil heaters and other types of heating has been removed as these are now no longer required. The rooms were heated appropriately on the days of audit.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The RN and the team leader have access to external specialist advice from the GP and DHB infection control specialists when required. There is a documented role description for the infection control coordinators (ICCs) including role and responsibilities is in place.</p> <p>The infection control programme is approved and reviewed annually. Infection rates are discussed at staff meetings. Staff are made aware of new infections through daily handovers on each shift and reporting. The infection control programme is appropriate for the size and scope of the service.</p> <p>There are processes in place to isolate residents with infectious conditions when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks documented since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.</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</p>	FA	<p>The ICCs are responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Collation, analysis and reporting of infection are discussed and explained at the management and staff meetings. The ICCs have access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>

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 service has documented policies and procedures in place that reflect current best practice. Policies have been reviewed and include reference to standard notification section 31. Staff were observed to be compliant with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and are able to locate policies and procedures.</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>Staff education on infection prevention and control is conducted by the RN, team leader and other specialist consultants. A record of attendance is maintained and was sighted. The training content meets best practice and guidelines. The ICCs have attended an external infection control training conducted by the local district health board to keep their knowledge current. External contact resources included: GP, laboratories and local district health boards. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections is appropriate to the size and complexity of the service. The ICCs review all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. All infections are recorded on the infection report form, this information is collated and reviewed and analysed by the ICCs who will advise staff and management of the outcome.</p> <p>Analysis includes identifying trends and comparisons against the previous years. GP is notified if there is any resistance to antimicrobial agents and evidence of GP involvement and laboratory reporting was sighted. The surveillance programme is reviewed during the infection control programme review.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of</p>	FA	<p>The restraint minimisation policy provides consistent definitions for restraints and enablers.</p> <p>No residents were using restraint or enablers on the day of the audit at the service. All staff</p>

restraint is actively minimised.		receive education regarding restraint minimisation and challenging behaviours.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	The policy around advanced directives states that only a competent resident can make an advance directive. Of the five resident files reviewed, all are correctly documented with the general practitioner determining a lack of competence to complete the directive further with a clinical decision made ‘not for resuscitation’. One was also signed by the Enduring Power of Attorney. The sample size was increased. A further two new resident files were reviewed and both service signed by the general practitioner and separately by the Enduring Power of Attorney. While currently the decisions align in the files reviewed, there is potential for the two decisions to be conflicting. The registered nurse was confused around who would sign the advance directive.	Three of seven resident files reviewed have an advance directive signed by the enduring power of attorney as well as by the general practitioner.	Ensure that only residents deemed competent are able to sign an advance directive or a general practitioner if a clinical decision is documented. 180 days

<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Moderate</p>	<p>An internal audit schedule is documented and has been implemented since January 2018. There is no evidence of discussion of results through meetings. Corrective action plans are documented when issues are identified e.g. through internal audits, staff meeting minutes or maintenance issues. At times, there is no documentation that confirms that resolution has been completed.</p> <p>The new owner took responsibility for the service in November 2017. There have been six weekly meetings starting in February 2018 with a meeting in March, May and August.</p> <p>There are renovations and some hazards identified. The staff meeting minutes do not evidence documentation of hazards and there is no confirmation in writing that these have been communicated to family and visitors. Those interviewed were aware of all current renovations and of any risks and hazards. There are notices in places warning people of immediate danger.</p>	<p>The staff meetings do not evidence discussion of internal audit results.</p> <p>Resolution of issues is not documented at all times when issues are identified.</p> <p>Meetings have not been consistently held as per schedule since new ownership.</p> <p>Hazards are not documented to evidence that staff, residents (where able), family and visitors have been informed.</p>	<p>Provide feedback to staff around results of internal audits with discussion of strategies to address issues.</p> <p>Document evidence of resolution of issues.</p> <p>Review the schedule of meetings to ensure these meet staff needs and that they are held regularly.</p> <p>Document evidence of communication of any hazard.</p> <p>60 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider</p>	<p>PA Low</p>	<p>The director/manager understands their responsibilities for reporting any change in management however the MoH and the District Health Board have not been formally informed of the change since the new ownership.</p>	<p>The MoH and the District Health Board have not been</p>	<p>Formally notify the Ministry of Health and the District Health</p>

understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.			formally informed of the change in management and clinical oversight.	Board of the change in management and clinical oversight. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Moderate	An orientation programme is documented with a separate programme for nursing staff. The programme does not include reference to dementia or to key aspects of care for people with dementia as outlined in the Age Related Care Contract.	The orientation programme does not include training around dementia or to key aspects of care for people with dementia.	Ensure that the orientation programme includes dementia or to key aspects of care for people with dementia. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	Training has been provided to staff including training around rights, documentation and some clinical issues. Training around dementia has not been provided and an annual training plan is not documented.	An annual training plan is not documented. Staff (including the registered nurse) have not all had training in dementia.	Document an annual training plan. Provide training to all staff on dementia. 90 days

<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA Moderate</p>	<p>Rosters were reviewed for the past two months. Most shifts include a staff member who has completed NZQA approved training on dementia however some shifts (particularly in the weekend) indicate that there is not always a staff member on duty who has completed training in dementia (refer also 1.2.7). Staff have access to a registered nurse at any time and state that they do ring if there any queries. The registered nurse and director/manager also confirm that staff ring with queries around clinical care and operational matters if required. The pharmacist and general practitioner state that staff ring with any concerns.</p>	<p>Not every shift has a staff member who has completed training in dementia</p>	<p>Ensure that each shift has staff member who has completed training in dementia.</p> <p>90 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Low</p>	<p>There is a four-weekly rotating winter and summer menu in place. The residents have a diet profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. The menu has not been reviewed by the registered dietitian to confirm it is appropriate to the nutritional needs of the residents. The food service has not been registered under the new food control plan.</p>	<p>The food service is not being provided in line with recognised nutritional guidelines.</p>	<p>Provide evidence that the menu was reviewed by the registered dietitian.</p> <p>Ensure the food service is registered under the new food control plan.</p> <p>180 days</p>
<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</p>	<p>PA Moderate</p>	<p>The planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Residents' files have a documented activity plan that reflects their preferred activities and are evaluated every six months or as when necessary however some files had no 24- hour activities plan in place to manage residents with behaviours of concern. Activities staff complete the assessment in line with timeframes for the completion of the InterRAI.</p>	<p>Not all files sampled had 24-hour activities plans in place.</p>	<p>Include 24-hour activities plans in residents' files to guide staff in the management of behaviours of concern.</p>

the consumer.				90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.