

Capella House Limited - Capella House

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 Q-Audit 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:	Capella House Limited
Premises audited:	Capella House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 26 August 2019 End date: 27 August 2019
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:	29

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

Capella House provides rest home, hospital and secure dementia care services for up to 29 residents. On the day of the audit there were 29 residents. Four of these were younger people under 65 years old (three in the dementia unit and one in the hospital).

The service is family owned and operated There have been no changes in management since the last audit.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board (DHB). The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

No areas of improvement have been identified during this audit. Continuous improvement ratings have been awarded for quality and risk management and for the activities program.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and families are provided with information about the Health and Disability Commissioners Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents. The residents' cultural, spiritual, individual values and beliefs are assessed and acknowledged.

There is an appropriate complaints process that is known to staff, residents and families. A complaint register and associated records are maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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The organisation is governed by an owner director who owns two other aged care facilities. The operation of the facility is undertaken by a facility manager (FM) who is supported by a clinical nurse manager (CNM). Organisation performance is closely monitored by the director.

Business and quality plans include the scope, direction, goals, values and mission statement of the organisation. The facility is managed by an experienced and suitably qualified person. The facility manager provides monitoring reports of the services to the owner / director.

The quality and risk management system include collection and analysis of quality improvement data, identifies trends and is used to improve services. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery, are readily available to all staff and are reviewed regularly for currency and relevance.

The screening, appointment, orientation and management of staff is based on current good practice in dementia and aged care. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes monitoring of competency and regular individual performance review. Suitably qualified staff are on site over the 24-hour period. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents are assessed prior to entry to the service to establish the level of care. The processes for assessment, planning, provision, evaluation, review and exit are provided by suitably qualified staff. InterRAI assessments and individualised care plans are documented.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Twenty-four-hour activity needs are identified in individual care plans. There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP).

The food service is provided onsite and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met. A food control plan was in place. 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.

The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested and tagged annually. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Cleaning and laundry processes are managed by staff and regularly evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Families reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

There is a secure dementia unit onsite and there is a key pad entry to the grounds which enables visitors to come and go as they please. There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint and two were using enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education in restraint, challenging behaviours and de-escalation

techniques through in-service training. Health care assistants (HCAs) working in the dementia unit have completed dementia course.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control co-ordinator, aims to prevent

and manage infections. Specialist infection prevention and control advice is accessed from the district health board, and an external provider.

The programme is reviewed annually. Staff demonstrated good principles and practice around infection control, guided by relevant policies and supported with regular education.

Aged care specific infection surveillance data is gathered, analysed and trends identified. Results are reported throughout the organisation. Follow up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	45	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Capella House has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumer Rights (the Code). Staff interviewed understood the requirements of the Code, in particular with residents with dementia, and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training as verified in the training records.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled show that informed consent has been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) or residents and the general practitioner makes a clinically based decision on resuscitation authorisation. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</p> <p>In collaboration with hospice Capella House has implemented the palliative outcomes initiative resulting in all residents either having or being in the process of developing end of life plans</p>

		(Refer 1.2.3.8).
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have support persons. The clinical nurse manager and staff provided examples of the involvement of advocacy services in relation to residents' care.
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.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and associated records meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission. Those interviewed knew how to make a complaint and stated that they felt comfortable making any concerns known to staff and to the manager if necessary. The complaints process, forms and a drop box are provided in the residents' lounge.</p> <p>The complaints register was reviewed and three complaints sampled. Records indicated that appropriate actions had been taken, through to an agreed resolution, were documented and completed within the timeframes defined in the complaints policy. Action plans also show that any required follow up and improvements have been made where possible.</p> <p>The FM is responsible for complaints management and works with the clinical lead registered nurse to review and follow up all received. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required on their part.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
Standard 1.1.2: Consumer Rights During	FA	Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and

<p>Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>English. Family members interviewed were aware of consumers' rights and confirmed that information was provided to them during the admission process.</p> <p>The information pack outlines the services provided. Resident agreements signed either by the resident or by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.</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' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with the residents in the secure dementia wing able to move freely into the surrounding secure gardens while those in the hospital wing can go in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The clinical nurse manager (CNM) reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. The GP reiterated that there was no evidence of any abuse or neglect reported. Family/whanau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</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>The required policies on cultural appropriateness are documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identifies barriers to access. It also recognises the importance of whanau. Assessments and care plans document any cultural/spiritual needs. Special consideration to cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff have received cultural awareness training. There were no residents who identify as Maori at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	FA	<p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal</p>

services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		preferences and special needs were included in care plans sampled.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and residents reported they felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The CNM stated that there have been no reported alleged episodes of abuse, neglect or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through ongoing professional development of staff. Implementation of training and education for long term care givers resulted in all completing level three and four qualifications. The service received Alzheimer's Society Dementia Friendly Award with 100% compliance in relation to provision of care, community engagement, safe and appropriate environment and staff morale (Refer 1.2.3.8). Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff know how to access interpreter services if required. Staff can provide interpretation as and when needed; the use of family members and communication cards is encouraged.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the</p>	FA	<p>The strategic and business plans were developed by the director and the FM and outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans and were last reviewed in August 2018. Monthly reports to the owner provide information to monitor performance</p>

needs of consumers.		<p>including financial performance, emerging risks and issues.</p> <p>The service has 29 beds over three wings and holds contracts with the DHB for 19 rest home care – dementia over two wings and 10 dual hospital / rest home care – geriatric. On audit day there were 19 stage three dementia care residents and 10 hospital level residents. There were four residents under the age of 65 years, one in hospital care and three in dementia care. No one was receiving respite care.</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>	FA	<p>The facility manager is suitably skilled and experienced for the role. The FM was previously assistant manager at another aged care facility for two years, has relevant business healthcare knowledge with a business degree majoring in psychology and has been in this role for four years. Responsibilities and accountabilities are defined in a job description and an individual employment agreement. The manager interviewed confirms a good understanding of the aged care sector including dementia care and regulatory and reporting requirements.</p> <p>The CNM is responsible for all clinical matters and deputises for the FM. The CNM is a registered nurse, trained Career Force assessor and InterRAI trained nurse. The CNM has completed the Palliative Outcomes Initiative training (POI) with hospice and is the Link Nurse at the facility.</p> <p>Both the FM and the CNM have completed NZQA dementia papers and advanced dementia care papers through the University of Tasmania. They maintain currency through attending training at the DHB and the NZ Aged Care Association annual industry conferences.</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>	FA	<p>There is a documented and implemented quality and risk management system. Policies on audits, surveys and questionnaires, document control, the reporting and meeting cycle, and quality and risk management policy address quality management processes with an emphasis on continuous improvement in all areas.</p> <p>Policies on procedure development and review and document control address the management of policies, procedures, forms and templates and the management of obsolete documents. Master copies are held electronically and secured by password. The date of development, version number and review date for each document are stated. Archived documents are stored in a secure area. Each policy includes a rationale and references. Hard copy policies and procedures are available to staff in the FM office.</p> <p>The business and quality plan is linked to the strategic directions and addresses the goals, actions, time frames, person's responsible, evidence of progress, measurement, outcomes</p>

		<p>expected and accountabilities. The development, implementation and monitoring of the business plan sits with the FM and the owner director.</p> <p>The FM, the director and the CNM form the leadership team and meet monthly. The agenda includes policy review, monthly reports, staff issues and training, the quality improvement register (QIR), complaints, infrastructure, health and safety including accidents and incidents and service user feedback.</p> <p>A range of internal audits are completed including consumer rights, quality and risk management, service delivery and environment. Actions are taken to remedy deficits and implement improvements. All policy or template updates are approved. Records of internal audits sampled confirmed a link to the quality system, with improvements made as required. Improvements are documented in the quality improvement register. The achievement of the quality system in relation to corrective and improvement actions is rated beyond the expected full attainment.</p> <p>There are regular staff meetings. The agenda includes accidents, incidents, and complaints. Staff interviewed confirmed knowledge of and commitment to the quality programme. Annual resident surveys are conducted with result indicating general satisfaction with care and services provided. Evaluations of service delivery, food service, complaints handling and family satisfaction are conducted annually. Analysed data is reported to the director, management and staff and actions taken to remedy and improve any identified issues.</p> <p>There is a documented risk management plan that is monitored monthly at the management meeting and reviewed annually by the director and the FM. Newly identified risks are reported to the director. There is a documented active health and safety system that complies with current work health and safety legislation. Health and safety is included in the induction of all new staff and is a standard item on the management meeting. Staff interviews and meeting minutes confirmed that health and safety is discussed at all staff meetings.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed confirmed these were fully completed, families notified appropriately, incidents were investigated, action plans developed and actions followed-up in a timely manner. Staff interviewed were aware of their reporting responsibilities in relation to resident and staff incidents, resources, security, and health and safety. Adverse event data is collated, analysed and reported to the owner and staff through the monthly meetings. Collated reports for 2018 and 2019 indicate reduced incidence across all categories.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries.</p>

		The FM advised there had been one notification of a significant event made to the Ministry of Health/DHB since the previous audit. Record sighted indicated correct processes were followed.
<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 management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes reference checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Credentials of contracted professionals and trades people are checked annually.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records sampled show documentation of completed orientation and an initial performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Training records confirmed it is implemented. Both session records and individual training records are maintained. All care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The CNM is the internal assessor for the programme.</p> <p>All care staff have completed or are in the process of completing, the required dementia care education. The facility received the Alzheimer's Society Dementia Friendly Recognition Award in June 2019 for improving uptake of dementia training by staff by 100% in six months. (Refer to CI awarded under Criterion 1.2.3.8). The CNM and one other registered nurse maintain annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals with all staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. A registered nurse is on duty at all times. The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place. The CNM and the FM are within 20 minutes of the facility after hours. Staff report that they are well supported and have good access to advice when</p>

qualified/skilled and/or experienced service providers.		<p>needed.</p> <p>Care staff undertake the cleaning and laundry duties and reported there were adequate staff available to complete the work allocated to them. Family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on each duty has a current first aid certificate.</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>A resident register is maintained of all current and past residents. Resident individual information is kept in paper format. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with GP and allied health service provider notes. Written records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Capella House's welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau where appropriate, local communities and referral agencies.</p> <p>Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whanau and residents 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</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification form 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</p>

coordinated transition, exit, discharge, or transfer from services.		discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.
<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>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe medication management system was observed. Indications for use are noted on 'as required' medications, allergies are clearly indicated, and resident photos are current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. All medicines are reviewed every three months for rest home residents and monthly for hospital residents unless they are stable and the GP deems that three monthly is sufficient.</p> <p>The medication records and associated documentation are in place. Medication reconciliation is conducted by the registered nurses when a resident is transferred back to service. The RNs or CNM check medicines against the prescription. There were no expired or unwanted medicines. Expired medicines are returned to the pharmacy in a timely manner. The service does not keep any vaccines. There were no residents self-administering medications. Self-administration medication policies and procedures are in place if required. The controlled drug register is current and correct. Weekly and six-monthly stock takes were conducted. Medication audit was conducted on 29 January 2019 and corrective actions have been acted on.</p> <p>The registered nurse was observed administering medications safely and correctly. All staff who administer medication have current medication administration competencies.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is an approved food plan for the service. Meals are prepared on site and served in the allocated dining rooms. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four-weekly rotating winter and summer menu in place.</p> <p>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. 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 when required. The family members and residents interviewed acknowledged satisfaction with the food service.</p>

		All food services staff have completed training in food safety/hygiene. The kitchen and pantry were clean, tidy and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.
<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 CNM reported that all consumers who are declined entry are recorded and when entry is declined residents and relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure that the consumer will be admitted to an 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	Residents have their level of care identified through needs assessment by the assessment agency. Initial assessments are completed within the required time frame on admission while resident care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau, residents and other health team members as appropriate. Additional assessments are completed according to the need for example; behavioural, nutritional, continence, skin and pressure assessments. The nursing staff utilise standardised risk assessment tools on admission. In interviews conducted family/whanau and residents expressed satisfaction with the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	The assessment findings in consultation with the resident and/or family/whanau, inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans are used for short-term needs. Family/whanau and residents interviewed confirmed they are involved in the care planning process. Resident files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, district nurses, physiotherapist, podiatrist, dietitian and GP.
Standard 1.3.6: Service	FA	Interventions are adequate to address the identified needs in the care plans. The individual

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>behaviour management plans specify prevention-based strategies for minimising episodes of challenging behaviours and describe how the residents' behaviour is best 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. The GP reported that medical input is sought in a timely manner, that medical orders are followed, and care is person centred. Care staff confirmed that care is provided as outlined in the care plan. A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents' needs.</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>	FA	<p>The activities program has been awarded a continuous improvement rating.</p> <p>The facility has a strong focus on activities that residents enjoyed pre-entry to service. The planned activities are appropriate 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. A residents' activities interest form is completed within two weeks of admission in consultation with the family and residents were able. The activities are conducted by a qualified diversional therapist (DT). The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. The activities are varied and appropriate for residents in the hospital wing, residents under 65 years, people living with dementia and are offered from Monday to Sunday.</p> <p>Twenty-four-hour activity interventions are identified in the long-term care plans and these were sighted in all files sampled. Residents' files have a documented activity plan that reflects their preferred activities of choice and are evaluated every six months or as necessary. The residents were observed to be participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents and family members interviewed reported overall satisfaction with the level and variety of activities provided.</p> <p>A continuous improvement rating has been awarded for a quality improvement project that resulted in normalising dementia care in a secure facility and improving the connection residents have with the local community and families/whanau.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is documented on each shift by care staff in the progress notes. The registered nurses complete progress notes daily and as necessary. All noted changes by the care staff are reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a</p>

		<p>resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change. These are carried out by the RNs in conjunction with family, GP and specialist service providers. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans are reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers where required. If the need for other non-urgent services are indicated or requested, the GP and the nursing team sends a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the CNM, registered nurses or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. There is a designated maintenance person who ensures minimum quantities of hazardous substances are held onsite. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets (MSDS) were available where chemicals were stored. Staff interviewed knew what to do should any chemical spill/event occur. Secure storage is provided for rubbish awaiting council collection. There is provision and availability of protective clothing and equipment and staff were observed using this.</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 residence comprises three joined wings on the one floor level, one open wing for hospital residents, and two secure wings, one for mixed gender dementia residents and one for male only dementia residents. The layer provides a secure environment for male residents with behaviour issues. The current building warrant of fitness (expiry date 27 June 2020) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Security is maintained through coded door catches set high</p>

		<p>above the door with code displayed for ready access by staff and visitors. All secured doors release automatically when a fire alarm is activated.</p> <p>The testing and tagging of electrical equipment and calibration of bio medical equipment is undertaken annually as confirmed in documentation reviewed and observation of the environment.</p> <p>Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted. Secure external areas are safely maintained and were appropriate to the resident group and setting. The walking paths are designed to encourage purposeful walking around the garden. A safe, sheltered external area is provided for smokers. The front gate is a coded gate catch with the code clearly displayed.</p> <p>Staff, family members confirmed they knew the processes they should follow if any repairs or maintenance were required, that any requests are appropriately actioned and that they were happy with the environment.</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>	FA	<p>All resident rooms have handwashing facilities and supplies. Each wing has sufficient accessible shower and toilet facilities for the number of residents in that wing. Bathrooms have signs, handrails and call bells, are well lit, ventilated and heated. Installations, walls and floorings are in excellent condition. Separate staff and visitor facilities are provided.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are 29 single bedrooms with bedside tables, wardrobes and a chair. All bedrooms have opening windows, call bells and a light over the bed. Rooms are large enough for easy movement with mobility aids. The hospital rooms are large enough to accommodate the use of hoists. Residents can have personal items in their bedrooms. Each room is identified by the resident's name or a picture or item that enabled the resident to know their own room.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe,</p>	FA	<p>Each wing has a communal lounge and dining area with ample room for the number of residents in that wing. The lounges each open into a sun porch that leads to the garden. There is a television area off the main lounge. A variety of seating is provided to meet all resident's needs. Flooring is carpet tiles or vinyl and maintained in very good condition. There are no changes of</p>

adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.		level. Handrails are provided in all corridors.
<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>	FA	<p>Laundry is undertaken on site by caregivers in a dedicated laundry and by family members if requested. There is clear separation of clean and dirty areas in the laundry. Care staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. There is an external area with a clothesline so washing and cleaning items can be dried outside. Family and residents interviewed reported the laundry is managed well and the residents' clothes are returned in a timely manner.</p> <p>Care givers undertake some cleaning duties on each shift. They confirmed they had received appropriate training in cleaning processes. There is a separate cleaning room with a low sluice and sink. Chemicals are stored in a lockable cupboard and were in appropriately labelled containers. MSDS sheets are available in the cleaning room and staff interviewed confirmed that they had read them during their orientation.</p> <p>Cleaning and laundry processes are monitored through regular feedback from staff and family, and the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Emergency planning considers the unique needs of people with dementia. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or another emergency. Staff receive training in first response to clinical emergencies and are encouraged to maintain first aid certification. There are sufficient staff with fit aid training to ensure there is one on every shift. There is a registered nurse on duty at all times. There is a detailed disaster recovery plan.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service in 2015 and there have been no changes to the building or the services provided since then. All secured doors release automatically when a fire alarm is activated. The facility has smoke alarms, sprinklers, fire hoses and extinguishers throughout. Monthly checks were sighted. A trial</p>

		<p>evacuation takes place six-monthly and records indicate that all staff have attended at least once in the last 12 months. The orientation programme includes fire and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas BBQ were sighted and meet the requirements for the number of residents. A water storage tank and a generator are available if required. Emergency lighting is regularly tested. Call bells and sensor mats alert staff to residents requiring assistance. Call system audits are completed on a regular basis. Families and residents interviewed reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and staff do security checks at night.</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 residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and communal areas have doors that open onto secure outside garden areas. Heating is provided by heat pumps with wall panel heaters available for supplementary heating if required. Areas were warm and well ventilated throughout the audit. Residents and families interviewed confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme is reviewed annually through an annual report with trend analysis and has goals for the upcoming year.</p> <p>The CNM is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results are reported monthly to the FM and to the monthly staff and management meetings.</p> <p>The infection control manual provides guidance for staff about how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.</p>

		<p>There are family meetings that cover aspects of infection control and if they are unwell, it is recommended that they do not visit the service. During higher risk times of community infections and winter months notices are placed at the door to remind people not to visit if they are unwell, there is sanitising hand gel at the entrance and throughout the service. Hand washing and sanitiser dispensers are readily available around the facility.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control coordinator has appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control.</p> <p>Additional support and information are accessed from an external infection control agency, the infection control team at the DHB and the GP as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinator confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.</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>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists. Policies were last reviewed in November 2018 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Staff interviewed verified knowledge of infection control policies and practices.</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>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the infection prevention and control coordinator and external specialists. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>Compliance with hand hygiene processes was the subject of an education project in 2018 resulting in improvement from 65% compliance in March 2018 to 100% in March 2019 and</p>

		<p>maintained to date. (Refer to CI awarded under Criterion 1.2.3.8).</p> <p>Education with residents is generally on a one-to-one basis and has included subjects such as encouraging fluids, reminders about handwashing, advice about remaining in their room if they are unwell. The family meetings are used to remind families and visitors regarding standard precautions.</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>The surveillance programme is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The infection control coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs, with short term care plans developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Where there has been an increase in infections, corrective actions are implemented. There has not been any recorded outbreak of infections since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Capella House is committed to providing quality services for residents in a safe environment and work to minimise the use of restraint. The service currently has no residents using restraint and has two residents using enablers. Approved restraint and enablers include bedrails, lap belts and bed loops. Environmental restraint is in place in form of coded locked doors where codes are displayed, and family/whanau come and go as they please. A restraint register was sighted.</p> <p>All staff receive education regarding restraint minimisation and management of challenging behaviours. Interviewed staff were clear regarding the difference between a restraint and enabler use. Restraint minimisation and dealing with challenging behaviour training was conducted on 25 February 2019 and twenty-five staff members attended.</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, there 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
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	CI	<p>The achievement of the quality system in relation to corrective actions is rated beyond the expected full attainment. Quality improvement projects have been developed and implemented to address improvement opportunities. The process includes documenting actions to make improvements including a documented review process which includes the analysis and reporting of findings. The projects include:</p> <p>Compliance with hand hygiene: Staff education, installation of hand sanitizer dispensers in all areas and frequent monitoring resulting in improvement from 65% compliance in March 2018 to 100% in March 2019 and maintained to date.</p> <p>Implementation of the Palliative Outcomes Initiative (POI) to deliver the best possible quality of life for palliative hospital patients and their family/whānau in the facility. The CNM trained as a Link Nurse with the local hospice. The link nurse then provides training and advice to staff. The initiative centres around a family / whanau meeting to identify the needs and wishes of the resident and family.</p>	<p>The achievement of the quality system in relation to corrective and improvement actions is rated beyond the expected full attainment. Quality improvement projects have been developed and implemented to address improvement opportunities. The process includes documenting actions to make improvements including a documented review process which includes the analysis and reporting of findings.</p>

		<p>A plan is developed for staff to follow. The project is commenced in March 2019 and to date has resulted in all residents having, or being in the process of developing, an end of life plan or advanced directive.</p> <p>Dementia Friendly Recognition Award: In June 2019 the facility achieved a two-year certification against the seven elements of the Alzheimer's Society Dementia Friendly Program. The program assesses achievement in relation to information resources, acceptance and awareness in the local community, facility and fittings, care of residents with dementia, and staff morale. Reviews are completed every six months. The facility has improved from 50% compliance in 2018 to 100% compliance in 2019.</p> <p>Pay Equity Project: At the time of the introduction of the care giver pay equity legislation in 2017 only 25% of facility staff qualified for a pay increase despite many years of experience in dementia care. In 2018 a concerted effort was made to support long term staff to undertake qualifying dementia education papers resulting in 100% now having Level 3 or 4 certificates.</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 the consumer.</p>	CI	<p>An improvement project was implemented that aimed to get the residents outside and involved in the community as much as possible. Every single staff member from the facility contributed towards this goal- from gardeners and cooks to nurses and management. In order for this goal to be successful and implemented seamlessly, the whole team worked together to ensure that meaningful activities do not cease when the activities team go home.</p> <p>The diversional therapist (DT), facility manager and clinical nurse manager provide constant training and support to staff in achieving this goal. The cooks and kitchen hands have residents in the kitchen almost every day. The care staff actively get residents assisting them in their daily duties such as vacuuming, setting tables, collecting the chickens' eggs for the day, folding the washing, doing the dishes etc. The maintenance manager works alongside the DT in getting residents to help where appropriate.</p>	<p>The achievement of the quality improvement project in the activities program and implementation of meaningful activities throughout facility and into the community is rated beyond the expected full attainment. With the project there has been a documented review process which includes the analysis and reporting of findings. Positive inclusion of the residents in everyday activities and creation of opportunities for interaction with the community have resulted in increased staff knowledge, confidence and skill in developing and increasing resident's skills and participation in activities. Positive outcomes have been measured in staff, resident and relative satisfaction.</p>

		<p>Some of the scheduled activities have included: Three bus trips a week; Visits to the library; Visits to local schools for dress rehearsals of productions etc; Daily walks/drives to complete errands, get the mail/post mail/get haircuts/pick up milk etc; Church visits by a local Christian Centre; Church Visits by a local Church; Regular entertainment sessions (dancing/singing/karaoke/magicians/puppet shows/clowns etc); Yoga and pet therapy sessions.</p> <p>Based on the feedback received by the facility from those working in dementia agencies, mental health services, the GP, residents, families and staff, the program has added to residents' wellbeing and ultimately their symptom management, challenging behaviours have reduced, particularly during 'sun-downing periods', staff have a better understanding of the importance of encouraging meaningful activities in the residents' daily lives and report that they are more satisfied at work and feel more included and connected. Families have acknowledged the improved quality of life of their loved ones with residents demonstrating improved mood and reduced restlessness. There have been longer and more positive family visits where families have joined in events, including joining the residents in the community. Awareness of dementia and the work of the facility have been raised in the local community.</p> <p>Capella House won the Invacare Small Operator Industry Award for this project in 2017 and was runner up in the Medi-Map Community Connections Award in 2018.</p>	
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End of the report.