

Avon Lifecare Limited - Avon Life Care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Avon Lifecare Limited
Premises audited:	Avon Life Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 4 November 2019 End date: 5 November 2019
Proposed changes to current services (if any):	Three additional resident rooms were verified (one rest home, one hospital and one dementia care) to bring the total beds available to 90 across the three service levels. This audit has verified the service as suitable to provide hospital (medical) level of care.
Total beds occupied across all premises included in the audit on the first day of the audit:	78



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

Avon Lifecare has been privately owned since January 2019. The owner/director also operates another local aged care facility. Avon Lifecare provides care for up to 90 residents across rest home, hospital and dementia service levels. On the day of audit there were 78 residents.

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

The facility manager appointed two months ago is an experienced aged care manager. She is supported by an experienced clinical manager and two-unit coordinators. The business manager oversees the non-clinical services.

Residents and relatives interviewed were complimentary of the service and care under the new ownership and management.

This certification audit did not identify any areas for improvement.

The service has been awarded a continuous improvement rating for the reduction of challenging behaviours.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

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

Information about the services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent.

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.


Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

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

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. The manager is a registered nurse (RN) who is on site five days a week. The registered nurse clinical manager is on call when not on site. The facility manager is supported by a team of RNs, including two designated unit coordinators.

There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

Continuum of service delivery

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

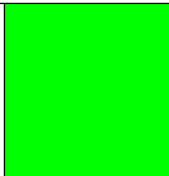
Medication policies reflect legislative requirements and guidelines. Registered nurses and senior healthcare assistants responsible for administration of medicines complete education and medication competencies. The electronic medicine charts reviewed, met prescribing requirements and were reviewed at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

The activity team coordinates the separate activity programmes for rest home, hospital and dementia care units. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and

cognitive abilities and preferences for each resident group. Residents and families reported satisfaction with the activities programme.


All meals and baking are prepared and cooked on site. Residents' food preferences and dietary requirements are identified at admission. Special dietary requirements and dislikes are accommodated. Nutritional snacks are available 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The separate buildings both hold a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with access to shared ensembles or communal facilities. Documented policies and procedures for the cleaning and external laundry services are implemented with appropriate monitoring systems in place. Documented systems are in place for essential, emergency and security services. There is a staff member trained in first aid on duty at all times.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. During the audit there were two residents using enablers and no restraint in use.

Infection prevention and control

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

Summary of attainment

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

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

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Information around the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is in the information pack provided to residents and families during entry to the service. Information is also posted up on walls. The policy relating to the Code is implemented.</p> <p>The facility manager and care staff interviewed (three RNs including two-unit coordinators, six healthcare assistants and one diversional therapist) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through the staff education and training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents (including outings and indemnity) were obtained on admission as sighted in eight of nine resident files reviewed including two rest home residents (one in a dual purpose bed and one resident under long-term stay – chronic health condition -LTS-CHC)), three hospital residents (including a younger person with physical disability) and two dementia care residents (including one under a compulsory treatment order-CTO). One dementia care resident did not have completed consent and was under a CTO. Specific consents were sighted such as influenza vaccines.</p> <p>Advance directives if known, were on the resident files. Resuscitation plans were sighted in all files and were</p>

<p>informed choices and give informed consent.</p>		<p>signed appropriately. The GP deemed if the resident was competent or not and a medically indicated decision was evident for incompetent residents. Copies of EPOA were present and activated as required. An EPOA was to be appointed for the dementia care resident under CTO.</p> <p>Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed, confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>All residents' files sampled had a signed admission agreement on file. The admission agreement also included permission granted such as photographs and release of medical information.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Health and Disability Commissioner (HDC) advocacy details are included in the information provided to new residents and their family/whānau during their entry to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations.</p> <p>Community links are established with local community groups. Family and residents interviewed praised the service and remarked that it was part of the community.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms are located at the entrance to the facility. The complaints process is linked to advocacy services.</p> <p>An electronic and paper-based record of complaints received is maintained by the facility manager. Ten complaints have been lodged in 2019 (year-to-date) and were reviewed. Complaints have been being managed in accordance with HDC guidelines. One complaint was lodged around the care of one resident and the DHB have</p>

<p>understood, respected, and upheld.</p>		<p>been involved and are satisfied with the outcome. A trend in complaints about meals have resulted in a service improvement plan for meals and a review of staffing in the kitchen. The recent survey (July 2019) score 92% satisfaction with meals and residents and family interviewed all noted improvements with the meal service.</p> <p>Discussions with residents and families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code and the HDC advocacy service are included in the resident information that is provided to new residents and their families. The facility manager (RN) or clinical manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly residents' meetings and bi-annual relatives' meetings. All seven residents (three hospital and four rest home) and two family (one rest home, one hospital) interviewed, reported that the residents' rights were being upheld by the service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The residents' personal belongings are used to decorate their rooms. The healthcare assistants interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas and this was observed on the days of audit. Staff reported that they promote the residents' independence by encouraging them to be as active as possible. Residents and families interviewed and observations during the audit confirmed that the residents' privacy is respected.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect, which begins during their induction to the service. This training is repeated annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges</p>	<p>FA</p>	<p>A Māori health policy is documented for the service. Links are established with Te Komiti Whakarite – Nga Hau National Marae. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. There were three residents living at the facility who identified as Māori (one at hospital level and two from the dementia wing). Cultural considerations were included in care plans.</p> <p>Education on cultural awareness begins during the new employee's induction to the service and continues as an annual training topic.</p>

their individual and cultural, values and beliefs.		
<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>The service identifies the residents' personal needs and desires from the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents' care plans, evidenced in all nine care plans reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are described in job descriptions. Interviews with the care staff ((3 hospital, 2 dementia, 1 rest home) confirmed their understanding of professional boundaries including the boundaries of the healthcare assistants' role and responsibilities. Professional boundaries are reconfirmed through education and training, staff meetings, and performance management if there is infringement with the person concerned.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	CI	<p>The facility manager/registered nurse is on site five days a week and is supported by a team of RNs, including two-unit coordinators. Residents are reviewed by a general practitioner (GP) every three months at a minimum.</p> <p>Resident meetings are held two-monthly. Residents and family/whānau interviewed reported that they are very satisfied with the services received. This was also confirmed in the 2019 resident/family satisfaction survey.</p> <p>The service receives support from the district health board (DHB). Physiotherapy services are provided four hours a week and as needed.</p> <p>The environment allows for close relationships between the staff and residents.</p> <p>The new facility manager has implemented a range of quality improvements. The progress of quality improvements has been monitored by the facility manager and owner and also through facility meetings. Recent improvements have included; the creation of a new nurses' station in the dementia unit, refurbishment of the main</p>

		<p>lounge, and a new laundry.</p> <p>A continuous improvement has been awarded for the management of behaviours that challenge.</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>There is an open disclosure policy; management, registered nurses and care staff interviewed understood open disclosure and providing appropriate information when required.</p> <p>Families interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Fourteen accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. There was one resident at the facility who was unable to speak or understand English. This resident's care plan included comprehensive communication strategies which included a communication book with basic signs and the use of family as interpreters.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Avon Lifecare provides rest home, hospital and secure dementia levels of care for up to 90 residents. There are 20 beds in the secure dementia unit, 31 rest home level beds and 39 hospital level beds (all dual-purpose beds). The service has a contract for end of life care and respite as well as the DHB contract.</p> <p>On the day of the audit there were 78 residents. This included; 34 rest home level residents - one funded through the Long-Term Support - Chronic Health Conditions (LTS-CHC) contract. There were 26 residents at hospital level including; one younger person. There were 18 residents assessed at dementia level care in the secure dementia unit including one funded through mental health services.</p> <p>This audit has included verifying the service as suitable to provide hospital (medical) level of care. There is appropriate allied health input including (but not limited to) a contracted physiotherapist. The older persons mental health service is also readily accessible with fortnightly community mental health nurse visits. The service also has sufficient equipment for the needs of hospital- medical residents. A further three rooms were verified as part of this audit as suitable for the level of care (one rest home, one hospital and one dementia care). These rooms were originally offices that have been renovated and converted to resident rooms. Overall bed numbers have increased from 87 rooms to 90 rooms.</p> <p>A philosophy, mission, vision and values are in place. The business plan for 2019 has been regularly reviewed by the manager and the owner of the facility with many of the business goals achieved since the service was purchased during January 2019. The facility manager reported that she meets regularly (as frequently as daily) with the owner.</p> <p>The facility manager is an RN who was previously the quality adviser for the service and who had many years of</p>

		management experience in the aged care sector. She has maintained a minimum of eight hours of professional development per year relating to the management of an aged care facility.
<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	There is a clinical manager who is responsible for clinical operations in the absence of the facility manager. The owner assumes administrative responsibilities in the absence of the facility manager.
<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>The service has a fully implemented quality system purchased from an external consultant. The quality improvement plan includes' improvements to food services, improving education opportunities for healthcare assistants, facility renovation and improving activities. The facility manager reviews progress against goals monthly.</p> <p>Policies and procedures align with current good practice and meet legislative requirements, and they are suitable to support hospital (medical) level of care. Policies have been reviewed, modified (where appropriate) and implemented. New policies are discussed with staff.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. Data is collected for a range of adverse event data (eg, skin tears, falls, infections) and is collated and analysed. An internal audit programme is being implemented. Where improvements are identified, corrective actions are documented, implemented and signed off by the facility manager.</p> <p>Regular family meetings are held in the dementia unit with the last in October. Families are also invited to hospital and rest home two monthly resident meetings.</p> <p>The resident/relative survey (sept 2019) identified that relatives from dementia were very satisfied across all area.</p> <p>Monthly quality meetings document comprehensive review and discussion around all areas including; hazards, service improvement plans, emergency processes, complaints, incidents and accident, internal audits, infections</p>

		<p>and a range of clinical outcomes such a weight management, pressure injuries and interRAI as examples.</p> <p>A risk management plan is in place. Health and safety policies reflect current legislative requirements. Interviews were conducted with the health and safety officer who is the maintenance person who is supported by the facility manager. Staff health and safety training begins during their induction to the service. Health and safety is a regular topic covered in the staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. A plan is implemented to orientate contractors to the facility's health and safety programme.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, intentional rounding with two-hourly checks, and challenging behaviour plans.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service's quality and risk management programme. Fourteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurological observations are conducted for suspected head injuries.</p> <p>The facility manager is aware of statutory responsibilities in regard to essential notification with examples provided (eg, reporting grade three or higher, pressure injuries). Two section 31 reports have been sent during 2019 for pressure injuries (community acquired).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice</p>	FA	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (four healthcare assistants, three RNs, including the clinical manager, one diversional therapist and the maintenance person) included evidence of the recruitment process, including reference checking, signed employment contracts and job descriptions, and completed orientation programmes.</p> <p>The orientation programme provides new staff with relevant information for safe work practice that is specific to the job role. Staff interviewed stated that new staff were adequately orientated to the service.</p> <p>Ongoing training is offered to all staff that meets contractual obligations. The service uses a combination of on-line training, guest speakers, in-service training and additional training is also provided through staff meetings.</p>

<p>and meet the requirements of legislation.</p>		<p>Competencies are completed specific to worker type. Registered nurse training and competences include; syringe driver, medication and wound care. A register of current practising certificates for health professionals is maintained.</p> <p>All nine RNs, including the clinical manager, have completed their interRAI training. Training records demonstrated that when a resident is admitted with a care need that is not familiar to staff, immediate training is given in brief form, prior to or at the time of admission and a more comprehensive training when this can be arranged.</p> <p>Twelve healthcare assistants work in the dementia unit; ten have completed the dementia unit standards and two newer staff are in the progress of completion.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy aligns with contractual requirements. The clinical manager/RN is on site five days a week and is on-call when not available on site 24/7. A business manager is available on call for non-clinical related issues.</p> <p>There are two-unit coordinators appointed. One-unit coordinator oversees the hospital residents and one oversee rest home and dementia level residents. One is on duty Monday to Friday and the other works Sunday to Thursday. Staffing is flexible to meet the acuity and needs of the residents.</p> <p>Hospital rest home wing (26 hospital level residents' and 8 rest home on the day of audit).</p> <p>AM; one RN and six HCAs (three long and three short shifts). PM; one RN and five HCAs (three long and two short shifts). Night; one RN and two HCAs.</p> <p>Rest home only wing (26 rest home residents).</p> <p>AM; two HCAs, PM; one long shift and one short shift HCA, Night; one HCA.</p> <p>Dementia unit (18 residents).</p> <p>AM; two long shifts and a lounge carer/activities person until 6.30 pm. PM one long shift and one short shift. At night there is one HCA.</p> <p>There is a shared RN with the dementia and rest home wing.</p> <p>An activities person and a diversional therapist are rostered over seven days a week.</p> <p>Interviews with residents and families confirmed staffing overall was satisfactory.</p>
<p>Standard 1.2.9: Consumer Information</p>	<p>FA</p>	<p>The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Personal</p>

<p>Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>resident information is kept confidential and cannot be viewed by other residents or members of the public. Archived records are secure in a separate locked area.</p> <p>Residents' files demonstrated service integration. Entries were legible, dated, timed and signed by the relevant healthcare assistant or RN, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs for each service level are provided for families and residents prior to admission. The information pack for dementia level of care contains relevant information relating to a secure unit. Admission agreements were reviewed and aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. Admission agreements for long-term residents had been signed within the required timeframe.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medications were stored safely in each of the three units. Clinical staff who administer medications (RNs and senior healthcare assistants) have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The RN checks incoming medication blister packs against the electronic medication chart. A medication verification form is signed when the packs have been checked. Impress stock including antibiotics is maintained for hospital level residents and there are regular checks of stock level and expiry dates. All medications were within the expiry dates. Eyedrops and sprays were dated on opening. Medication fridge temperatures were monitored and recorded daily. Standing orders are not used. There was one rest home resident self-medicating and there was a current self-medication assessment in place. The pharmacist</p>

<p>practice guidelines.</p>		<p>visits weekly and is readily available for any advice or support.</p> <p>All 17 medication charts were reviewed on the electronic medication system. One paper-based medication chart was reviewed for one GP not on the electronic system. All GP prescribing met legislative requirements. The GP has reviewed the medication charts three monthly. There were photographs, and allergy status identified on the medication charts. The effectiveness of 'as required' medications are recorded in the electronic medication system.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The service employs cooks and kitchenhands to prepare and cook all meals on site. There is a summer and winter menu that has been reviewed by a registered dietitian (20 June 2019) who also provides dietetic input around the provision of special menus and diets where required. The cook receives a resident dietary assessment completed by the RN for all residents and is notified of any dietary changes or weight loss. The residents' individual food, fluids and nutritional needs are met. Dislikes, food allergies and cultural requirements are accommodated. The kitchen is adjacent to the rest home dining room and meals are served from the kitchen bain marie to the residents. Meals are delivered to the hospital and dementia unit serveries in hot boxes. Specialised utensils and lip plates are available to assist residents with independence at mealtimes. There were nutritional snacks available in the dementia unit 24 hours. Staff were observed to be assisting residents with food and fluids at mealtimes.</p> <p>The chiller, fridge and freezer temperatures are taken and recorded daily. End-cooked food temperatures and serving temperatures are taken and recorded at each meal. The kitchen was observed to be clean and all aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines with the Food Control Plan in place.</p> <p>Feedback on satisfaction with meals is obtained from residents through resident meetings. Residents and relatives interviewed were satisfied with the meals offered stating the service had improved over recent months.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</p>

their family/whānau is managed by the organisation, where appropriate.		
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN completes an initial assessment (in the electronic resident management system) on admission, including applicable risk assessment tools. Behaviour assessments had been completed for the two dementia files reviewed. An interRAI assessment is undertaken within 21 days of admission, six monthly, or earlier due to significant changes in health. The younger person was not required to have an interRAI assessment. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident (as appropriate), family and significant others. The long-term care plans in place reflected the outcome of the assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The electronic initial care plan populates the long-term care plan which is updated by the RN within three weeks of admission. The long-term care plans are printed and available in resident files for care staff to access. Resident care plans reviewed were resident focused and individualised. All identified support needs as assessed, were included in the care plans for all resident files reviewed. The outcomes of interRAI assessments link with the long-term care plan supports and interventions. Behaviour management plans were in place for dementia care residents with de-escalation strategies including a 24-hour activity plan that identifies the resident's pattern of behaviour. (over the 24 hours). Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were notified of an upcoming MDT review and were involved in the care planning process. Resident files demonstrated service integration. There was evidence of allied health care professionals involved in the care of the resident including the GP, physiotherapist, dietitian, community mental health services and social worker.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition alters, the registered nurse initiates a nurse specialist review and if required a GP consultation. There was evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the resident family/whānau contact sheet held in the resident file.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for three residents (two hospital and one rest home). There were no pressure injuries. There was pressure injury prevention equipment readily available to minimise pressure injuries. The service has access to the Nurse Maude wound nurse specialist if required.</p>

		<p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain, re-positioning, neurological observations food and fluid intake, bowel monitoring and behaviours of concern.</p> <p>Long-term care plans are updated for any changes to health.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service has a qualified diversional therapist (DT) who works alongside another DT and a staff member currently progressing through the DT training. The two DTs are fulltime and the DT in training is part time. One of the DTs works as a weekend manager and as a DT across the hospital and dementia care units. There is a dedicated programme for each area - hospital, rest home and dementia care, with some shared activities across the areas.</p> <p>The activity programme and hours has been reviewed under new management, resulting in additional activity hours in the dementia unit from 10 am and 6 pm (link CI 1.1.8.1). The programme is planned a month in advance and reflects the cognitive and physical abilities of the groups of residents. Healthcare assistants support residents to attend activities of their choice within their unit or to integrated activities such as musical performers, happy hours and church services.</p> <p>Each unit programme reflects meaningful activities such as (but not limited to); baking, gardening, household tasks, garden walks exercises, word games, art, flower arranging and news and views. One-on-one activities such as individual walks, chats and discussions, reminiscing and games occur for residents who are unable to participate or choose not to be involved in group activities. A new initiative has been the “activity trolley” (resources) in the dementia unit which is easily accessible for residents and families.</p> <p>There is an individual activity plan for the younger person (LTS-CHC) which includes community connections and meaningful household tasks. One-on-one time is spent with the resident to ensure their recreational needs are being met.</p> <p>Community visitors to the service include entertainers, speakers, pre-school children, churches, hospital chaplain and canine friends. Festivities and themes are celebrated with a showtime theme for November, which included Melbourne Cup day and NZ Trotting Cup. There are regular outings for rest home and dementia care residents and the wheelchair taxi is hired for hospital resident scenic drives. All of the activity team have current first aid certificates.</p> <p>An activity assessment and activity plan are completed on admission in consultation with the resident/family as appropriate. There is a 24-hour daily activity plan for dementia care residents. Activity plans in all files were</p>

		<p>evaluated six monthly at the same time as the care plan at the MDT meetings with the resident/relative.</p> <p>Residents and families are able to provide feedback and suggestions for the programme through meetings, surveys and one-on-one feedback. Residents and families interviewed on the day of audit commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans have been evaluated at least six monthly or earlier for any health changes against the resident goals or transfer to higher level of care within the facility. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes and are evident in changes made to care plans. Family are invited to the MDT meetings and if unable to attend are informed of changes to the care plan as documented in the family contact sheet. Written evaluations document if the resident goals have been met or unmet. The care staff are asked for input into the evaluation of the care plan. The RN, DT, physiotherapist, resident/relative and other health professionals involved in the care of the resident are involved in the MDT meeting.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Residents requiring a higher level of care are referred to the needs assessment service for re-assessment as evidenced for one hospital resident requiring dementia level of care.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors,</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. There is an external locked chemical room where chemicals are delivered and stored until required. There is a chemical pre-mixing system in place. Chemical bottles sighted have correct manufacturer labels. Safety data sheets and product information is readily available. The chemical provider monitors the effectiveness of chemicals used. Personal protective clothing is available for staff and seen to be</p>

<p>and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>worn by staff when carrying out their duties on the day of audit. Relevant staff have completed chemical safety training. There are sluice rooms in each unit with appropriate personal protective wear available. There is a chemical spills kit available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There are two separate buildings. Holdsworth House is a 31-bed rest home facility. The 39-bed hospital unit and 20 bed dementia unit (Hiron-Trinity) are in Fitzgerald House. Both buildings have a current building warrant of fitness that expires 1 April 2020. The business manager oversees property and maintenance. There is a full-time maintenance person (qualified builder) who is responsible for the daily maintenance and planned maintenance across both buildings. A maintenance request folder is kept at the main reception area and is checked daily for repairs and maintenance requests which are signed off as completed. The planned maintenance schedule has been completed to date and includes indoor, outdoor and equipment (wheelchairs, hoists, electric beds) maintenance. There are essential contractors available 24 hours. Electrical equipment has been tested and tagged. Hot water temperatures in resident areas are monitored and maintained below 45 degrees Celsius. The service has converted three rooms (previously nurses station/office) into resident rooms – one in the rest home, one in the hospital and one in the dementia care unit. Each resident room viewed had an external window, was spacious enough to provide the level of care and had call bells. The new owners have refurbished most areas within the facility including, painting, new carpets and furniture, new reception area in the main foyer, new nurses' stations in the hospital and dementia unit, new hairdressing salon, new dining room in the dual-purpose wing for rest home residents, new dining room in the dementia unit and LED lighting throughout the facility.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There are safe ramps and rails to access the outdoor gardens and courtyards for each wing. Seating and shade are provided in the outdoor courtyards at both buildings. Two family members volunteer their time to maintain the gardens and grounds.</p> <p>Residents in the dementia care unit (Hiron-Trinity) have safe access to the large garden areas which are connected by walking pathways. There are several entry/exit doors from the unit to the outdoors with shade and outdoor seating.</p> <p>The care staff and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans such as hoists, pressure prevention resources, platform scales and electric beds. The service has installed a ceiling hoist.</p>
<p>Standard 1.4.3: Toilet,</p>	<p>FA</p>	<p>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are both shared</p>

<p>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>ensuites and communal use bathrooms/toilets in the hospital and the rest home building. There are adequate numbers of communal toilets/showers with engaged/vacant signs in place. There is a large shower room in the hospital with enough space for the use of a shower trolley. In the dementia unit, all toilets and showers are communal with privacy signs.</p> <p>Residents interviewed stated their privacy was respected when staff were attending to their personal hygiene needs.</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>At present all rooms in the rest home and dementia unit are single. There are two double rooms in the hospital unit. All rooms have adequate space to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The hospital/dual-purpose unit has a large open plan lounge/dining area and two smaller lounges for quieter activities or for visitors. There is a smaller dining room for rest home resident's in the dual-purpose hospital unit where tea/coffee making facilities are available. In the rest home unit, there is a dining room adjacent to the kitchen and a separate large lounge with doors that open onto the courtyard. There is a library lounge and hairdressers' room and seating alcoves throughout the rest home unit.</p> <p>In the dementia unit there is a spacious dining room area and a large communal lounge with seating arranged for small groups and individual activities. There is another quieter lounge available for quieter activities or visitors. There is safe access with ramps and rails to the outdoor courtyards and gardens.</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>The new owners have reinstated an on-site laundry for all personal clothing and linen. New equipment has been installed in the previously large storage area. There is adequate ventilation and external windows and good workflow within the laundry. There is an entry and exit door and defined clean/dirty area within the laundry. The laundry operates from 11 am to 9 pm. A designated HCA continues with laundry duties following their morning cares and, on the afternoon, following afternoon cares. The laundry is located in the hospital unit and the short shift HCA for morning and afternoon stats laundry duties at the end of their HCA shift. There is a new small domestic laundry in the dementia unit for the laundering of the resident's personal clothes completed by care staff. Both laundries are locked when not in use.</p> <p>There are two cleaners on duty each day. Cleaning trolleys in each unit are well equipped and kept in locked cleaners' cupboards when not in use. All staff have completed chemical safety training. Staff use a pre-mixed chemical system for the refilling of bottles which are correctly labelled. The service conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. The chemical provider monitors the effectiveness of laundry and cleaning processes. Residents and relatives interviewed were happy with the laundry service and the cleanliness of their rooms.</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>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months (at a minimum) with the last fire drill taking place on May 2019. There is a New Zealand Fire Service approved evacuation scheme. The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water and blankets. Two gas barbeques are available and a civil defence book in each area of the facility.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked monthly by maintenance. All call bells ring through to staff pagers.</p> <p>There is always at least one staff available 24 hours a day, seven days a week with a current first aid/CPR certificate. All staff are required to complete their first aid training.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p>	<p>FA</p>	<p>Residents were provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Double glazed windows have been installed in most areas.</p>

Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
Standard 3.1: Infection control management 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.	FA	Avon Life Care has an established infection control programme. The infection control programme has been reviewed for 2019. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A unit coordinator is the infection control coordinator. The infection control coordinator has support from all staff including the GP. Internal audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team have good external support from the GP and clinical specialists at the DHB. Infection prevention and control is part of staff orientation. Hand washing facilities are available throughout the facility and hand sanitiser is freely available. The service has a designated IC room which includes outbreak kits.
Standard 3.3: Policies and procedures Documented policies	FA	Avon Life Care has infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have

<p>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>		<p>been reviewed.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff and has completed DHB training in infection control. Infection control education has been provided in the past year. Staff receive education on orientation and one-on-one training as required.</p> <p>Information is provided to residents and visitors that is appropriate to their needs. Resident education occurs during care and as needed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected and reported monthly by unit for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at monthly meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. Overall infection rates are low and there has been no outbreak since previous audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraint minimisation. Two residents were using an enabler and no restraint was in use. Enabler use is voluntary. Two resident files using enablers were reviewed, all had monitoring completed within the required timeframes. Staff training records evidenced that guidance had been given on restraint minimisation and enabler usage.</p> <p>Staff receive training on restraint minimisation. The healthcare assistants interviewed were able to describe the difference between an enabler and a restraint.</p>
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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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.8.1</p> <p>The service provides an environment that encourages good practice, which should include evidence-based practice.</p>	CI	<p>At the end of 2019 the management team, with input from the staff in the dementia unit, identified an opportunity to reduce the incidence of challenging behaviour in the unit. Incidences of behaviours that challenge are monitored and reported at the monthly quality meetings.</p>	<p>A plan was developed that focussed on the activities programme, the environment, individual care planning, family education and staff hours.</p> <p>An experienced diversional therapist was employed and following her review the service purchased an activities trolley stocked with a variety of ‘hands on’ activities (such as ‘sorting’ activities, reminiscing activities and wool winders as examples). A quiet lounge with comfortable chairs and quiet, soothing music was set up for residents to enjoy with the family and staff. The entire unit was repainted with quiet soothing colours and wood panelling and new furniture purchased to create a homely atmosphere. New bed linen was also purchased which included personalised duvet covers for resident choice.</p> <p>The diversional therapist reviewed each resident’s 24-hour care plan with staff and family which focussed on the resident individual needs.</p> <p>Additional activities staff were rostered in the unit from 10 am to 6 pm each day to encourage activities and assist with sundowning behaviour later in the day.</p>

			As a result, the rate of behaviours that challenge reduced from an average of 2.5 incidence per 1000 bed days in June, July and August to nil during September, October and November to date.
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End of the report.