

Oceania Care Company Limited - St Johns Wood

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 Central Region's Technical Advisory Services 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:	Oceania Care Company Limited
Premises audited:	St Johns Wood
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 August 2017 End date: 22 August 2017
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:	42

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

St Johns Wood can provide rest home and hospital level care for up to 60 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. The audit process included the review of policies, procedures, supporting documents, resident files, staff files and observations, and interviews with residents, family, management and staff.

A rating of continuous improvement has been given around the activities programme.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff demonstrated an understanding of residents' rights and they incorporate this knowledge into their daily duties and care for the residents. Residents confirmed they are treated with respect. Residents receive services in a manner that considers their dignity, privacy and independence.

Information regarding resident rights, access to advocacy services and how to lodge a complaint, is available to residents and their family.

Residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to their care. Linkages with family and the community are maintained. The service has a documented and implemented complaints management system and the complaints register is current.

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 mission statement and vision of the organisation are documented. There is a current business plan and quality and risk management plan. Quality and risk management systems support service delivery and include internal audits, complaints management, resident and relative satisfaction surveys, and incident/accident management. Quality and risk management activities and responsibilities are shared among staff, residents and families. Policies have been reviewed.

The business, care and village manager is responsible for the overall management of the facility and is supported by the clinical manager and a regional and executive management team, including the clinical quality and regional operations manager.

There are human resource policies implemented around recruitment, selection and orientation. Rosters reflect staffing to meet acuity and resident levels. Rosters include staffing for residents in the occupational right apartments. The service has an information management system to ensure secure and safe management of resident and staff information. Staff, residents and family confirmed that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

Continuum of service delivery

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

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

Each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The initial assessments, the initial care plans and the long-term care plans are completed within the required timeframes. The long-term care plan evaluations are resident focused and occur six-monthly or more frequently when this is required. The short-term problems are recorded on short-term care plans and signed off when resolved. The residents and family interviewed confirmed their input into assessments, care planning and evaluation of care.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. The residents self-administering medicines do so according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. There is a central kitchen and on-site staff that provide the food service. The kitchen staff have completed food safety training.

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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All building and plant comply with legislative requirements which includes a current building warrant of fitness. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

The service has cleaning and laundry processes in place with cleaning and laundry teams responsible for implementation. The service is fit for the purpose, including the external environment. Essential emergency and security systems are in place with regular fire drills completed. Call bells enable residents to access help when needed.

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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The restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

There were two residents using restraint and no residents requesting enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour is provided.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. The policies and procedures guide staff in all areas of infection control practice. New employees are provided with training in infection control practices and there is ongoing infection control education available for all staff. Infection control is a standard agenda item at the facility's meetings. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirmed that the surveillance programme is appropriate for the size and complexity of the services provided.

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	49	0	0	0	0	0
Criteria	1	100	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>Staff at St Johns Wood receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their orientation to the service and through their annual training programme. Staff confirmed their understanding of the Code and could provide examples on how the Code is implemented in their everyday practice. This included maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.</p> <p>The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information. Education relating to the Code and complaints was last provided by Health and Disability Advocacy service, residents and families were invited to attend.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p>	FA	<p>The information pack on services at the facility includes informed consent. The RN discusses informed consent processes with residents and their families/whānau during the admission process. Staff confirmed their understanding of informed consent processes.</p> <p>The informed consent policy and procedure directs staff in relation to gaining informed consent. This included guidelines for consent for resuscitation/advance directives. Staff ensure that all</p>

consent.		<p>residents are aware of treatment and interventions planned for them, and that the resident and/or significant others are included in the planning of that care.</p> <p>All resident files identify that the required consents are collected. The GP identifies the level of resident competence in relation to their resuscitation status decision making ability, as part of the informed consent process.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the Health and Disability Commissioner office is provided to residents and families. Information on advocacy services is available at the service. Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney to be involved in decisions. Resident files included information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service does not have set visiting hours and family reported that they are free to visit at any time. Residents confirmed that they are supported and encouraged to access community services with visitors or as part of the planned activities programme. The service also encourages the community to be a part of the residents' lives with visits from entertainers and community groups (refer to 1.3.7).</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedures are in line with the Code and includes timeframes for responding to a complaint. Complaint forms are freely available to all residents and visitors. There is a complaints register in place which includes appropriate management processes such as: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. The complaints management processes comply with legislative requirements.</p> <p>There have been no complaints made to the Health and Disability Commissioner or other external agencies, since the previous audit.</p>
Standard 1.1.2: Consumer Rights During	FA	<p>Information on the advocacy service and the Code is available and displayed throughout the facility. The admission information packs reviewed included information on the Code, advocacy</p>

<p>Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>and complaints processes.</p> <p>Interviews with staff, residents and family confirmed an understanding of residents' rights. The business care and village manager (BCVM), clinical manager (CM) and registered nurses (RN) follow up with a discussion with residents and families during the admission process. Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service.</p> <p>Resident and family surveys indicated residents are aware of their rights and are satisfied with this aspect of service delivery. Residents and family interviewed received copies of the Oceania handbook. Families and residents are informed of the range of services, which are reflected in the service and admission agreements. Residents interviewed confirmed they had access to an advocate if needed. The BCVM advised that an advocate visits the facility on a regular basis and is also responsible for taking resident meetings.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has a philosophy that promotes dignity, respect and quality of life. This philosophy is supported with policies and procedures which are aligned with the requirements of the Privacy Act and Health and Information Privacy Code.</p> <p>Initial and ongoing assessments are completed to obtain detailed information on residents' beliefs and values, and are completed with resident and family input. Residents and family confirmed that they are included in the care planning process and addressed by their preferred name. Healthcare assistants (HCA) stated they support the residents' independence by encouraging them to be as active as possible.</p> <p>Discussions of a private nature are held in the resident's room and not in public areas; there are areas in the facility which can be used for private meetings. Healthcare assistants reported that they knock on bedroom doors prior to entering rooms. Signs are placed on the closed doors indicating cares are in progress. This was observed on the days of the audit. Residents and families confirmed that their privacy is respected.</p> <p>Staff have had education around abuse and neglect in 2017 and are able to describe the reporting process should any be identified. Family, staff, residents and the general practitioner (GP) stated that there is no evidence of abuse and neglect. Residents are supported to access spiritual support when needed and there are interdenominational services at least weekly.</p>
<p>Standard 1.1.4: Recognition Of Māori</p>	<p>FA</p>	<p>The service implements the Māori health plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/whānau to practise their own beliefs are acknowledged in</p>

<p>Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>the Māori Health Plan. The activities coordinator (AC) completes the cultural assessments on admission and updates six-monthly.</p> <p>The Māori advisor for Waikato District Health Board can be accessed for consultation by the service. There are two residents who identify as Māori living at the facility and cultural assessments have been completed. Interviews with residents and family confirmed their cultural needs are being met. Cultural training for staff is provided.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and family are involved in the assessment and the care planning processes. This was confirmed in interviews with residents and families. Information gathered during assessment includes the resident's cultural values and beliefs. Staff and family interviews confirmed that the service take additional care in making sure cultural needs of residents are identified and met.</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>Staff files have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. Families and residents expressed no concerns with breaches in professional boundaries, discrimination or harassment. Staff orientation and their employee agreement include standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the HCA's role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The organisational education programme is implemented annually and staff could describe sound practice based on policies and procedures. Consultation with health professionals and specialists is available to staff and they could describe how and when they would make contact. Staff have access to internet and Oceania intranet, should they need access to current best practice guidelines.</p> <p>Staff attend conferences and regional meetings to ensure knowledge is current. Residents and families interviewed expressed a high level of satisfaction with the care delivered.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide</p>	FA	<p>The complaints procedure, including incidents and accident reports and the open disclosure procedure, alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guided staff on the process to ensure full and</p>

<p>an environment conducive to effective communication.</p>		<p>frank open disclosure was available. Family members confirmed that they are informed if the resident has an accident/incident, or has a change in health or needs. Family contact is recorded in residents' files.</p> <p>Interpreting services are available from the district health board (DHB). Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Oceania Healthcare Limited's vision, values, mission statement and philosophy are recorded in the business plan, strategic plan, resident information pack and on the organisation's website. The organisation has systems in place recording the scope, direction and goals of the organisation. The business care and village manager (BCVM) provides monthly status reports to the support office. These reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators.</p> <p>The BCVM is supported by the clinical quality manager (CQM). The clinical manager's (CM) appointment is full time and is responsible for all clinical matters. The CM has worked for the organisation for 10 years and recently resigned, leaving the facility on the 25 September 2017. A new CM was appointed during the on-site audit. The BCVM has also resigned and will be leaving the organisation at the start of October 2017, after having been with the company for around three years. The organisation is currently in the process of advertising for a new BCVM. The BCVM from Wharerangi will be standing in for St Johns Wood in the interim (refer to 1.2.4).</p> <p>The facility can provide care for residents requiring rest home or hospital level of care. Occupancy during the onsite audit was 42 residents. On the day of audit there were 27 residents requiring hospital level care, 15 requiring rest home care including 1 resident receiving care under the young person disability (YPD) contract for under 65 year old residents. The service also holds contracts for respite and palliative 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>	<p>FA</p>	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the BCVM be absent. The current arrangement for oversight of St Johns Wood once the BCVM leaves, is for the BCVM of Wharerangi to provide leadership with support from the CQM and support office. The new CM will commence their role on the 25 September and interviews with the BCVM confirmed that the CM will be oriented and receive induction to their role with support from the team at Wharerangi and support office. The new CM has been working at the service as a RN for several years and has 10 years' experience in aged care.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>St Johns Wood uses the Oceania Healthcare Limited (Oceania) quality and risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required, and all policies are current. The support office reviews all policies, with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidence-based best practice guidelines. Policies are readily available to staff in hard copy. Staff interviewed stated new or revised policies are presented to them and they sign a form indicating that they have read and understood them. All clinical staff interviewed reported they are kept informed of quality improvements.</p> <p>There are monthly joint staff/quality and joint health and safety/infection control meetings held, that include all aspects of the quality programme. There are monthly resident meetings with family able to attend if they choose to. Resident meetings are conducted by an independent person from the local advocacy services. The meetings have agendas. Corrective action timeframes, completion dates and sign off were consistently recorded.</p> <p>Service delivery is monitored through review of complaints, review of accident/incident with monthly analysis of data, surveillance of infections, and implementation of an internal audit programme. Corrective action plans are documented and evidence of resolution of issues are documented when these are identified.</p> <p>Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk.</p> <p>Resident/family satisfaction surveys are completed six-monthly and results documented from the 2017 survey indicated that residents and family are satisfied with the service and environment and any suggestions for improvement are considered and actioned appropriately.</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>	<p>FA</p>	<p>Staff document adverse, unplanned or untoward events on an accident/incident form. Families are informed after adverse events, and this was confirmed in clinical records and during family and resident interviews. Accident and incident forms are reviewed and signed off by the BCVM. Corrective action plans address areas requiring improvement and are documented. There is an open disclosure policy.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Policy and procedures</p>

		<p>meet the terms of essential notification reporting for example: health and safety; human resources and infection control.</p> <p>The current CM resigned and is leaving on 25 September 2017. The new CM has been appointed to commence this role on 25 September 2017. Section 31 reporting in relation to the change of CM by Oceania support office when the change in role occurs.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Written policies and procedures in relation to human resource management are available including processes for allied health and other contractors. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and authority. These are reviewed on staff files along with employment agreements, reference checking, criminal vetting, drug testing, completed orientations and competency assessments.</p> <p>Annual practising certificates are reviewed for all staff that require them to practice and all are current. The CM is responsible for the in-service education programme. Competency assessment questionnaires are available and completed competencies were reviewed. Staff are supported to complete education via external education providers. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The BCVM advised that staff complete orientation and induction at employment. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments.</p> <p>The service has five registered nurses who have completed InterRAI training, including the CM, and the sixth RN is in the process of completing the training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. There is RN cover 24 hours a day. The service has eight RNs, including the clinical manager and the business care and village manager, with no new graduates.</p> <p>The service has 36 occupational right apartments, of which 27 were occupied. Fifteen of the residents in the apartments require assistance in their cares of daily living. The rosters allocate 10 hours of care from HCAs during the morning shift, with 4.5 hours of enrolled nurse oversight</p>

		<p>from Monday to Sunday in the apartments. In the afternoons, an HCA provides care for 5.5 hours in the apartments and at night the HCAs and RN from the hospital and rest home provide oversight of these residents, should they be needed. There is an assigned nurses' station from which staff provide care to the residents in the apartments, during the morning and afternoon shifts. The CM provides a monthly wellness clinic in which residents from the apartments have the opportunity to discuss health concerns and to have their vital signs checked.</p> <p>On call services after hours is provided by three senior RNs, the CM for clinical matters and the BCVM for non-clinical matters. Care staff interviewed reported adequate staff is available and that they can get through their work. Residents and family interviewed report staff provide them with adequate care.</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>Residents' information is stored securely in nurses' stations. Clinical notes are current and accessible to all clinical staff. Information containing sensitive resident information is not displayed in a way that it could be viewed by other residents' medical care or members of the public. Entries are legible, dated and signed by the relevant HCA, enrolled nurse (EN), RN or other staff member, including designation. Approved abbreviations are listed.</p> <p>The service retains relevant and appropriate information to identify and track resident's records. There is sufficient detail in resident's files to identify residents' ongoing care, history and activities.</p> <p>Documentation in individual resident files demonstrated service integration. The resident's national health index number, name, date of birth are used as the unique identifier. Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information.</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 and assessment processes are recorded and implemented. The facility information pack is available for residents and their family and contains all relevant information.</p> <p>The residents' admission agreements evidence resident and/or family and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements. The needs assessments are completed for rest home and hospital level of care. In interviews, residents and families confirmed the admission process was completed by staff in timely manner, and that all relevant admission information was provided and discussion held with staff in respect of resident care have been completed.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and coordinated manner. There is open communication between the service, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the progress notes. There was evidence of transfer information from other service providers in the clinical files reviewed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication area evidences an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The drug register is maintained and evidenced weekly checks and six-monthly physical stocktakes. The medication fridge temperatures are monitored and recorded and evidence temperatures are within the required temperature range.</p> <p>All staff authorised to administer medicines have current competencies. The medication round observed evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered. Staff receive education in medicine management.</p> <p>There were two residents self-administering medicines at the facility and this was conducted according to policy and medication guides.</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 food service policies and procedures are appropriate for the service setting. The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people, as verified by the dietitian's assessment of the planned menu.</p> <p>The residents' dietary requirements are identified on admission, documented and reviewed on a regular basis. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the chef.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight. The residents identified with unintentional weight loss have short-term care plans with required interventions and timeframes and weekly weight monitoring. Interview with the chef confirmed awareness of the residents' revised dietary forms and food fortification and high protein fluid requirements for residents identified with weight loss. The residents stated they were satisfied with the food service, reported their individual preferences are met and adequate food and fluids are provided.</p> <p>The food temperatures are recorded, as are the fridge, chiller and freezer temperatures. All</p>

		decanted food is dated. Kitchen staff have completed food safety training.
<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 BCVM stated that a process to inform residents and family in an appropriate manner of the reasons why the service had been declined would be implemented if required. The residents would be declined entry if not within the scope of the service or if a bed was not available. The BCVM stated there have been no declined entries to the service since their employment at the facility.
<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 residents' needs, outcomes and goals are identified via the assessment process and recorded. The facility has processes in place to seek information from a range of sources, for example: family; GP; specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.</p> <p>The facility has appropriate resources and equipment, confirmed at staff interviews. The assessments are conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and families confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</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	The residents' care plans are individualised, integrated and up to date. The care plan interventions reflect the risk assessments and the level of care required. The short-term care plans are developed when required and signed off by the RN when the short-term problems are resolved. In interviews, staff reported they receive adequate information for continuity of residents' care. The residents have input into their care planning and review. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview.
<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	The residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.

<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>CI</p>	<p>Interviews with the activities coordinator (AC) and management confirmed the activities programme meets the needs of the service group and the service has appropriate equipment. The AC plans, implements and evaluates the activities programme. There is one activities programme for the rest home and hospital residents. The activities programme provides activities specific to the residents' abilities, likes and enjoyment.</p> <p>Regular exercises and outings are provided for those residents able to partake. The activity programmes include input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. The residents' activities assessments are conducted on admission with the resident and family input and reviewed six-monthly. There are current, individualised activities care plans in the residents' files reviewed. The residents' activities attendance records are maintained. The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programme.</p> <p>The residents who wish to and are able to, actively participate in the community based programmes and events organised by the AC. Interviews with residents and family members confirmed the varied in-house activities programme, the community based programmes and the events are enjoyed and satisfaction is derived from being able to give back to the local community. The activities programme shows evidence beyond the expected full attainment.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Timeframes in relation to care planning evaluations are documented. The residents' care plans are up to date and reviewed six-monthly. There is evidence of resident, family, HCAs, activities staff and GP input in care plan evaluations. In interviews, residents and families confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>The staff enter data into the residents' progress records on each shift. When resident's progress is different than expected, the RN contacts the GP as required. Short-term care plans were in resident's files where required. The family are notified of any changes in resident's condition and this was confirmed at family interviews.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN</p>

<p>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>		<p>sends a referral to seek specialist service provider assistance from the DHB or other specialist services. Referrals are followed up on a regular basis by the RN or GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, and the resident is sent to DHB in an ambulance if the circumstances dictate.</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>	<p>FA</p>	<p>Processes for the management of waste and hazardous substances are documented and the hazard register is current. Policies and procedures for chemicals specify labelling requirements in line with legislation. This includes clear chemical labels which are easy to read and free from damage. Material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Interviews with the household staff confirmed this.</p> <p>Staff use personal protective equipment including: goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there are risks.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building warrant of fitness is current and displayed. The service has a planned maintenance schedule implemented with a test and tag programme. Checking and calibration of clinical equipment is completed annually.</p> <p>There have been no building modifications since the last audit. Interviews with staff and observation of the facility confirmed there is adequate equipment including: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet providing privacy when required. There is an outside area with shade, seating and outdoor tables. There are ramps and rails at entrance doors for access for residents with disabilities.</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</p>	<p>FA</p>	<p>The service has adequate numbers of accessible toilets/bathing facilities. Visitors' toilets and residents' toilets are located close to communal areas. All the toilets have a system that indicates if it is engaged or vacant.</p> <p>All the residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence. Auditors observed residents being supported to</p>

requirements or receiving assistance with personal hygiene requirements.		access communal toilets and showers in ways that are respectful and dignified.
<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>The service has adequate personal space in all the bedrooms to allow residents and staff to safely move around in the room. Equipment was sighted in hospital rooms needing this, with sufficient space for the equipment (for example hoists and wheel chairs), at least two staff and the resident.</p> <p>Residents' rooms are personalised with furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own.</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 service has lounges and dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, when required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. There is furniture in the garden areas and designated parking spaces for the mobility scooters.</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>	FA	<p>Laundry is completed on-site. Staff sort the personal laundry in the evening and HCAs are required to return linen to the rooms. Residents and family members confirmed that the laundry is well managed.</p> <p>There are cleaners on site during the day, seven days a week. Cleaners have a lockable cupboard to put chemicals in. The cleaners are aware that the cleaning trolley must be with them at all times. Cleaners were observed keeping the trolley in sight and limiting the chemical cleaning agents on the trolley.</p> <p>All chemicals are in appropriately labelled containers. Products are used with training about the use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and</p>	FA	<p>The service has an evacuation plan which has been approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. Fire drills are completed six-monthly. The orientation programme includes fire and security training. Checking the fire exits daily for clearance is on the maintenance daily schedule. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all</p>

<p>security situations.</p>		<p>equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including: food; water; blankets; emergency lighting and gas barbeques. An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways and dining rooms. Call bell audits are routinely completed and residents and family confirmed there are prompt responses to call bells.</p> <p>External doors leading to the gardens and outside doors are locked after sunset, these doors can only be opened from the inside. Staff complete a security check of all outside doors in the evening to confirm that security measures are in place.</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>	<p>FA</p>	<p>There are procedures in place to ensure the service is responsive to resident feedback in relation to heating and ventilation issues, should they arise. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Monthly room temperature checks are monitored.</p> <p>Family and residents stated that the building is maintained at an appropriate temperature in both winter and summer.</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>	<p>FA</p>	<p>The Oceania infection control policies and procedures manual provides information and resources to inform staff on infection prevention and control.</p> <p>The responsibility for infection control is defined in the infection control policy that includes: responsibilities of the Oceania IC committee (company-wide); infection control nurse and the infection control team. There is a signed infection control nurse's (ICN) job description outlining responsibilities of the position. The ICN is a RN who is supported in their role by the CM, BCVM and the infection control team. There is evidence of regular reports on infection related issues and these are communicated to staff and management.</p> <p>The Oceania infection control programme is reviewed annually by the Oceania infection control committee (company-wide). The facility's infection control programme is reviewed by the infection control team at the facility.</p>
<p>Standard 3.2: Implementing the infection</p>	<p>FA</p>	<p>The ICN has access to relevant and current information which is appropriate to the size and</p>

<p>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>		<p>complexity of the service, including but not limited to: the infection control manual; internet; access to experts and education. Infection control is an agenda item at the facility's meetings and this was evidenced during review of meeting minutes and interviews with staff. Infection control meeting minutes evidenced relevant infection control items and discussions are recorded and corrective actions are completed where required. The internal audit programme includes infection control audits to monitor the implementation of the infection control programme.</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>	<p>FA</p>	<p>The Oceania infection control committee (company-wide) develop and review the infection control policies and procedures to be implemented within the Oceania facilities. They are developed and reviewed regularly in consultation and input from relevant staff. The policies and procedures are up to date, reflect current accepted good practice and relevant legislative requirements. The infection control manual is readily accessible to all personnel and this was confirmed at staff interviews.</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 manual is introduced to new staff as part of their orientation to the service. Hand hygiene is part of the orientation process prior to staffs' commencement of work. Hand hygiene competencies are reviewed by staff annually and as deemed appropriate. Staff are required to complete infection control competencies. These were sighted in staff files and confirmed at staff interviews.</p> <p>The infection control education is provided to all staff, as part of the ongoing in-service education programme. The staff in-service education is provided by the CM and ICN. The education sessions have evidence of staff attendance/participation and content of the presentations. The ICN has conducted infection control education/training relevant to their role.</p> <p>In interviews, staff advised that clinical staff identify situations where infection control education is required for a resident such as hand hygiene or cough etiquette, and one on one education is conducted.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in</p>	<p>FA</p>	<p>The infection control surveillance policy identifies the requirements around the surveillance of infections. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection</p>

<p>accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>events, indicators or outcomes. Infection logs are maintained for infection events. Monthly surveillance analysis is completed and reported at facility's meetings and entered in the clinical indicators on the Oceania intranet. This information is reviewed by the Oceania clinical quality team and reported to the Oceania board monthly.</p> <p>The residents' files evidenced the residents who were diagnosed with an infection had short-term care plans in place. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The Oceania organisation-wide restraint minimisation philosophy is documented and the policy and procedures record the requirements for restraint minimisation and the use of restraint and enablers. The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There were no residents at the facility requesting the use of enablers and there are two residents using restraints.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</p> <p>In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice, enabler usage and prevention and/or de-escalation education and training was provided. The staff restraint competencies are current.</p>
<p>Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The Oceania clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally. Oversight of restraint use at each individual Oceania facility is the responsibility of the restraint coordinators. The restraint coordinator at St Johns Wood is the clinical manager (RN). The responsibilities for this role are defined in the position description. The restraint coordinator has completed training in restraint minimisation and restraint management relevant to their role.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The restraints are authorised following an assessment of the resident. The restraint assessments include: identification of restraint related risks; underlying causes for behaviour that requires restraint; existing advanced directives; past history of restraint use; history of abuse and or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes and possible alternatives to restraint. The approval of restraint use includes consultation with other members of the multidisciplinary team.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Strategies are implemented prior to the use of restraint to prevent the resident from incurring injury, for example, the use of low beds, mattresses and sensor mats. The consent forms for restraint use evidence consent is obtained from the GP, restraint coordinator and the resident and/or a family member. There have been no adverse events reported relating to restraint use at the facility.</p> <p>Restraints are recorded in the care plans and reviewed along with the care plan reviews. The restraint register is up to date and records all necessary information.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The evaluation of restraint occurs through restraint event reporting by the facility to the Oceania support office as a clinical key performance indicator. Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidence the restraint evaluation forms are completed and these include all the relevant factors in this standard. The restraint minimisation team meeting minutes evidence evaluation of each restraint use at the facility.</p> <p>The resident (if able) and the family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The ongoing evaluation of the effectiveness of restraint minimisation at the facility is the responsibility of the restraint coordinator. The national review of restraint is the responsibility of the Oceania clinical and quality team. There is evidence of monitoring and quality review of the use of restraints at the facility through bi-monthly meetings. National restraint benchmarking and analysis is reviewed monthly by the Oceania clinical and quality managers. The internal audit programme includes restraint minimisation and safe practice audits to monitor the compliance with the standard.</p> <p>The national restraint authority group terms of reference is documented and meetings are held</p>

		annually. This group reviews compliance with the approval of types of restraint; extent of restraint use; trends identified across Oceania care facilities; progress in reducing restraint nationally; adverse outcomes from restraint interventions; staff compliance with restraint programme policies and protocols; restraint practices and staff knowledge and competency in relation to restraint.
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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 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The 2017 satisfaction survey shows high satisfaction relating to activities in the service. The approach that is implemented relating to activities with the focus of ‘making a difference in the community’ is continuing within the facility.</p> <p>The community programmes and events that have been implemented continue to be supported and enjoyed by the residents, family and the wider community.</p> <p>The facility held a gala in November 2016 and advertised in the local newspaper. The public and the facility arranged stalls with items for sale for fundraising for the local hospice. The residents from St Johns Wood ran a cake stall, a men’s club stall and knit and knatter club stall. In the men’s club and the knit and knatter club, the residents make items with materials supplied by the community and these are donated to local kindergarten or auctioned or sold at gala days for fundraising purposes in the community. Interviews with the residents who participate in the men’s club and the knit and knatter club confirmed their enjoyment in being able to make items for the benefit of the local community.</p> <p>The facility also holds ‘support breakfasts’ open to the public, advertised in the local paper and on social media. The support breakfasts include a pink ribbon breakfast and</p>	<p>The activities programme shows evidence beyond the expected full attainment. The residents who wish to have an opportunity to contribute in a meaningful way to the wellbeing of the community are supported by the service and provided with opportunity.</p> <p>The activity programme evidenced the actions taken to make the programme meaningful to the residents.</p>

		<p>a prostate breakfast. Money raised was donated to these organisations and well supported by the local community.</p> <p>Another community project the residents of St John Wood have been involved in is a native planting fundraising project. The residents planted native trees for this cause. The funds raised were donated to a child in the St Johns Wood grand-friends programme who required support for their health treatment.</p> <p>Other residential care facilities in the area participate with St Johns Wood residents in competitions and activities.</p> <p>St Johns Wood residents in conjunction with the local kindergarten participate in the grand-friends programme. The grand-friends programme involves eight children visiting the residents fortnightly at the facility or residents visiting the eight children in the kindergarten. The children share time with the residents and this intergenerational programme initiative encourages residents to interact with children from the local kindergarten and vice versa. Interviews with the residents who partake in this programme expressed enjoyment and satisfaction in the grand-friends programme. The family members of the children who participate in the grand-friends programme stated it is a worthwhile programme for both the children and their families.</p> <p>Residents' survey specific to activities only was conducted in 2017 and the results are positive.</p>	
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End of the report.