

Windsor House Board of Governors - Windsorcare

Introduction

This report records the results of a Surveillance 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: Windsor House Board of Governors

Premises audited: Windsorcare

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 5 February 2020 End date: 5 February 2020

Proposed changes to current services (if any): A further two resident rooms in the rest home area were verified as suitable for dual purpose. This will increase the number of dual-purpose beds from 8 to 10, with the total number of beds remaining the same at 81.

Total beds occupied across all premises included in the audit on the first day of the audit: 73



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

Windsorcare service provides rest home, hospital and dementia level care for up to 81 residents. At the time of the audit there were 73 residents in total.

This unannounced surveillance audit was conducted against a sub-set of 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.

As part of this audit, a further two resident rooms in the rest home area were verified as suitable for dual purpose. This will increase the number of dual-purpose beds from 8 to 10, with the total number of beds remaining the same at 81.

The service has a general manager who is responsible for operational management of the service. He is supported by a management team including a clinical manager, contracted quality manager/RN, an HR/payroll manager and long serving staff.

The three previous shortfalls identified around; mandatory training attendance, care planning and neurological observations monitoring have been addressed. The continuous improvement previously awarded around the activity programme continues.

This audit identified no areas for improvement.

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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There is evidence that residents and relatives are kept informed of any changes. A system for managing complaints is in place, complaints were well managed.

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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Key components of service delivery is linked to the quality management system. There is an implemented internal audit programme to monitor outcomes. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to staff and quality and risk management meetings.

There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings.

The staff training programme is implemented and based around policies and procedures. Annual resident and relative satisfaction surveys are completed. Monthly meetings are held.

Human resources are managed in accordance with good employment practice and meeting legislative requirements. An orientation programme is in place. The service has sufficient staff allocated to enable the delivery of care.

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.

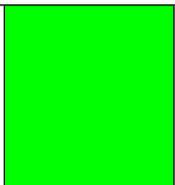
The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed in resident records demonstrated service integration and had been evaluated at least six monthly. Resident files included interRAI assessments, medical notes by the contracted GP and visiting allied health professionals.

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

A team of diversional therapists and activity assistants implement and coordinate the activity programme for the residents at rest home, hospital and dementia level of care. The programme includes community visitors and outings, entertainment and activities and integrated 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.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. There is a reactive and planned maintenance programme in place. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade.

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 practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. At the time of the audit there were two residents using restraint and one resident using an enabler. Staff have received training on restraint minimisation and the management of challenging behaviours.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. The 2018 and 2019 outbreaks were well managed.

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	16	0	0	0	0	0
Criteria	1	42	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The general manager maintains a record of all complaints, both verbal and written, by using a complaint's register. Six complaints/concerns made in 2019 evidenced appropriate action was taken. Documentation including acknowledgement letters, follow-up letters and resolution dates demonstrated that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed are followed up and implemented. One complaint was investigated by planning and funding with no findings. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. There have been no complaints received for 2020 YTD.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Comprehensive information is provided at entry to residents and family/whānau. Four residents interviewed (three rest home and one hospital) stated that they were welcomed on entry and were given time and explanation about the services and procedures. Both the general manager and clinical manager were available to residents and relatives and they promote an open-door policy. Incident forms reviewed from January 2020 evidenced that relatives had been notified on all occasions. Four relatives interviewed (three dementia and one hospital) advised that they are notified of incidents and when residents' health status changes promptly. The two registered nurses, one enrolled nurse, six caregivers, two cooks and the two diversional therapists interviewed fluently described instances where relatives would be notified. Newsletters are available for relatives.</p>

conducive to effective communication.		
<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>Windsorcare provides rest home, hospital (medical and geriatric) and dementia level care for up to 81 residents. On the day of the audit there were 73 residents in total, including 20 of 20 rest home residents, 34 of 41 hospital level residents, including one resident on an end of life contract, and two residents on respite. There were 19 of 20 dementia care residents including one resident on respite. All permanent residents were on the age-related residential care (ARRC) contract. This audit has also included verifying a further two rooms in the rest home area as suitable for dual purpose as per the MOH letter dated 2 October 2018. This increases the dual-purpose beds from eight to 10. The total number of beds remain at 81.</p> <p>The service is governed by the Windsor House board of governors (eight volunteer governors on the board). The board meets monthly and receives reports on all aspects of service delivery at Windsor House. The general manager reports to the monthly board of trustees meeting. The service is in the process of reviewing the 2019 strategic plan and quality and risk management programme and preparing the 2020 plan. The organisation has a philosophy of care which includes a mission statement.</p> <p>The general manager has a PhD in management and has been in the role for five years. He is supported by an experienced clinical manager, contracted quality manager/RN an HR/payroll manager and long-standing staff.</p> <p>The clinical manager has been in the role for two years and provides clinical oversight at Windsorcare. She has previous experience in aged care and clinical management.</p> <p>The general manager and clinical manager have completed in excess of eight hours of professional development in the past 12 months.</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</p>	FA	<p>Windsorcare has a business plan and a quality and risk management programme that outlines objectives/goals which is currently under review. The quality and risk process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality and risk performance is reported across the facility meetings. A 2019 annual summary has been prepared and was discussed at the combined quality meeting and displayed on the staff noticeboards. There are monthly combined quality/management/infection control and health and safety meetings, and a monthly clinical meeting. Meeting minutes sighted evidenced there is discussion around quality data including complaints, compliments, health and safety, accident/incidents, infection control, internal audit and survey results. Caregivers interviewed stated they are well informed and have ready access to meeting minutes and quality data which is displayed in the staffroom (sighted). Monthly reports by the general manager to the board of governors provide a coordinated process between service level and organisation.</p> <p>Quality initiatives at Windsorcare in 2019 included (but not limited to) provision of a regular relative and resident</p>

<p>principles.</p>		<p>support meeting which is held in the evening to allow working relatives to attend, this is well attended and has received good feedback. Isolation trolleys are now in place in all the units. Individual mailboxes have been made available for nurses, a container has been purchased to store all emergency equipment and supplies and the filing and document management systems have been reviewed and improved. The quality objectives are discussed regularly, progress towards completion is documented and signed off when completed.</p> <p>There is an annual satisfaction survey which was last completed in December 2018. Overall results reported that residents and relatives are satisfied with the service. Areas of high satisfaction included the gardens, grounds and internal environment, residents felt their rights were upheld, and a high standard of care was provided. Areas with mixed results included the activities and food services. Corrective actions were put into place to include extending the activities programme across seven days and increasing social engagement across the whole facility to include the residents in the village. The residents in the village are invited to attend inhouse entertainment, and the residents in the facility attend village activities as they wish. There has been a focus on improving the food services and dining experiences, including a menu review. Results were discussed at the combined quality meeting and discussed with the staff. The December 2019 survey has been delayed as the service are reviewing the template and survey processes.</p> <p>Health and safety is discussed at the combined monthly meeting. Staff interviewed could fluently describe hazard management. The quality consultant has attended a health and safety forum provided by the CDHB and reported information back to the combined meeting. The hazard register is up-to-date and was last reviewed in January 2020.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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</p>	<p>FA</p>	<p>Ten accident/incident forms (two rest home, four hospital and four dementia care) were reviewed for January 2020. All incident forms identified relatives' notification, timely RN assessment of the resident. Corrective actions to minimise resident risk were included in the resident care plans. Neurological observations had been completed as per protocol for unwitnessed falls and any known head injury. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted.</p> <p>The general manager, clinical manager and quality consultant interviewed could describe situations that would require reporting to relevant authorities. There were four section 31 notifications reported in 2019 including the two outbreaks, one non-facility acquired pressure injury and one facility acquired pressure injury.</p>

of choice in an open manner.		
<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>Seven staff files were reviewed (the clinical manager, one RN, one EN, one diversional therapist, the three caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. All staff must complete annual competencies prior to their appraisal. The register of nursing practising certificates and allied health professionals is current.</p> <p>The in-service education programme for 2019 has been completed and the 2020 programme is being implemented. Staff attendance has been more than 50% at compulsory training. A spreadsheet is maintained of all training for clinical and non-clinical staff. The attendance is monitored and recorded. Staff are reminded through the noticeboards and reminders using the time target system. The previous finding has been addressed.</p> <p>Nine of ten RNs have completed their interRAI training. Staff complete competencies relevant to their roles. All staff rotate through all of the units. Twenty-eight caregivers who work in the dementia care unit have completed the dementia unit standards. Caregivers are encouraged to complete NZQA qualifications. There is an assessor on site.</p> <p>Thirty-four staff have Careerforce qualifications and a further 10 have L4 equivalent qualifications.</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 an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The electronic roster provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager and clinical manager work full time from Monday to Friday. The general manager is available 24/7 for any operational or facility concerns and the clinical manager is on call for any clinical issues. Residents and relatives stated there were adequate staff on duty at all times. Staff interviewed felt that they are supported by the management who respond quickly to afterhours clinical or facility concerns.</p> <p>Registered nurses have a roster pattern of four on – two off. Due to this, there are often more than two nurses on duty. In this case, one RN completes documentation.</p> <p>In the hospital area, there are 34 of 41 hospital residents (including the resident on the end of life contract and three rest home level residents).</p> <p>There are two RNs on the morning and afternoon shifts and one on the night shift. The RNs are supported by eight caregivers; 4x 7 am to 3 pm, 2x 7 am to 1 pm and 2x 8.30 am to 12.30 pm. The afternoon shift has eight caregivers; 3x 3 pm to 11 pm (one of these is used as a 'float'), 2x 3 pm to 9.30 pm and 2x 4 pm to 8 pm.</p> <p>In the rest home area, there are 20 rest home residents.</p>

		<p>There are three caregivers; 2x 7 am to 3 pm (one of whom is medicine competent), and 1x 8.30 am to 12.30 pm. The afternoon shift has two caregivers rostered; one 3 pm to 11 pm (medicine competent) and 1x 3 pm to 9.30 pm.</p> <p>In the dementia care area, there is 19 of 20 dementia residents.</p> <p>One of the enrolled nurses (four on - two off) covers four hours of her shift in the dementia unit and four hours in the cottages.</p> <p>There are three caregivers rostered on the morning shift; 2x 7 am to 3 pm (one medicine competent), and 1x 8.30 am to 12.30 pm. The afternoon shift has three caregivers rostered; 2x 3 pm to 11 pm (one medicine competent) and 1x 4.30 pm to 8.30 pm.</p> <p>The night shift for the facility has one registered nurse and four caregivers. One caregiver is based in the dementia unit, and three in the hospital/rest home areas. One of the caregivers relieves the caregiver in the dementia unit for breaks.</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>There are policies and procedures in place for safe medicine management that meet legislative requirements. The main medication room is located in the hospital unit with locked medication trolleys/cupboards in the nurse's station of the rest home and the dementia care unit. Clinical staff who administer medications (RNs, ENs and senior caregivers) have been assessed for competency on an annual basis. Registered nurses have completed syringe driver training and they are supported by the hospice for palliative care. Education around safe medication administration has been provided. Medications are received in blister packs and checked by the RN against the medication chart and signed off on the medication reconciliation form. Any discrepancies are fed back to the pharmacy. 'As required' blister packs are checked weekly for stock and expiry dates. A bulk supply order is maintained for hospital level residents. There were no self-medicating residents. The medication fridges and medication room air temperature monitoring are completed daily. All eye drops were dated on opening.</p> <p>Eleven medication charts reviewed on the electronic medication system and one paper-based medication met legislative prescribing requirements. All medication charts had photo identification and allergy status noted. The GP had reviewed the medication charts three monthly. All medications had been administered as prescribed. Outcomes had been recorded for 'as required' medications.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's</p>	<p>FA</p>	<p>All meals at Windsorcare are prepared and cooked on site in a well-equipped kitchen. A head cook is supported by a second cook and catering assistants. There is a four-weekly seasonal menu which had been reviewed by a dietitian. The main meal is at midday. Dislikes and resident preferences are known and accommodated. Pureed/soft meals are provided as requested. Meals are plated in the kitchen, covered with insulated lids and delivered to the areas by trolley. Jugs of fluids, smoothies and high protein drinks are made daily and delivered to</p>

<p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>the areas. There are nutritional snacks available 24 hours in the dementia care unit.</p> <p>The service has a food control plan that expires December 2020. End-cooked food temperatures, re-heating and serving temperatures are taken recorded on each meal. Fridge, freezer and chiller temperatures are taken and recorded daily. Temperatures of inward goods are recorded. The dishwasher is checked regularly by the chemical supplier. All food services staff have completed training in food safety and hygiene and chemical safety. A kitchen cleaning schedule is in place and implemented. Dried goods and perishable foods are dated.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Resident care plans reviewed were individualised and detailed to reflect the outcomes of assessments. Care plans documented current supported to meet all assessed resident needs. The format of the long-term care plan includes prompts for cares and detailed individual interventions to support the residents. The previous finding around care plan documentation to meet resident needs has been addressed. Caregivers interviewed stated the care plans provided enough information to guide the safe delivery of care. Relatives interviewed confirmed they were involved in the care planning process. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process.</p> <p>There were 24-hour activity plans for residents with dementia that included morning, afternoon and night-time habits/behaviours and de-escalation techniques including activities. Behaviour plans linked to the interRAI assessments with appropriate interventions and monitoring requirements.</p> <p>Resident files demonstrated service integration. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, dietitian, palliative care nurse, community geriatrician and gerontology nurse specialist and older person mental health service.</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</p>	<p>FA</p>	<p>When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. Discussions with families and notifications are documented in the resident files on the relative contact form and include GP visits, medication changes, infections, accident/incidents, multidisciplinary meetings, appointments and referrals.</p> <p>Adequate dressing supplies were sighted in the hospital treatment rooms. Wound management policies and procedures are in place. Wound assessments, wound maps, treatment and evaluations including photos and short-term care plans were in place for all current wounds (13 in the hospital, six in the rest home and one in the dementia care unit). Chronic wounds were linked to the long-term care plans. Change of dressings and evaluations had occurred at the required frequency. The wound nurse had been involved in the management of chronic wounds and</p>

desired outcomes.		<p>vascular specialist for vascular ulcers. There were no pressure injuries.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>There are a number of monitoring forms used to monitor a resident's health status. Residents are weighed monthly or more frequently if weight is of concern. Monitoring occurs for weight, vital signs, blood glucose, pain, food and fluid intake, two hourly positioning, challenging behaviours and neurological observations. Weekly weigh monitoring and daily blood pressure monitoring had been completed as per GP instructions. The previous finding around monitoring forms and neurological observations has been addressed.</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>	CI	<p>The service employs two qualified diversional therapists (DT) and two activity assistants who develop and implement the separate wellbeing activity programmes for the rest home, hospital and dementia unit. The programme is provided from Sunday to Friday with resident led or caregivers initiated on Saturdays. The programme identifies integrated activities that all residents are invited to attend in the entertainment room such as bowls, entertainment, exercises, movies, happy hour, inter-home visits and celebrations/events.</p> <p>Each unit also has activities that are meaningful and meet the resident preferences, physical and cognitive abilities of the resident group. There are one on one activities such as individual walks, wheelchair walks, massage, reminiscing reading, arts and crafts that occur for residents who are unable or choose not to be involved in group activities. Volunteers are involved in the activities and include, one on one visiting and chats, board games, church services and visiting dog therapy. The dementia care programme is flexible around the residents needs and include sensory activities such as baking, gardening and crafts. Residents as suitable, under supervision, attend integrated activities. The Clown Doctors continue to engage with residents and a men's group and ladies' group has been formed. The service has maintained a CI rating round activity.</p> <p>There are regular outings and drives for all residents (as appropriate) including visits to the library and shopping. The service has a van and a mobility van is hired for monthly hospital level residents. The DTs have current first aid certificates. An activity assessment and plan are completed on admission in consultation with the resident/family (as appropriate). Activity plans in all files were reviewed six monthly. Families are invited to the resident meetings in the rest home and the hospital. There are three monthly support meetings for families of dementia care residents. The service also receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families. Residents and families interviewed were very satisfied with the activities offered.</p>
Standard 1.3.8: Evaluation	FA	All initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six monthly or earlier for any health changes for long-term residents. Written evaluations

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>documented if the resident goals had been met or unmet and changes made by the RN to reflect the resident's current needs/supports. The resident (as appropriate) and family are involved in the multidisciplinary review. 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.</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 has a current building warrant of fitness that expires 1 January 2021. A request list is completed for any maintenance and repairs and entered into a computer data base. An annual planned maintenance schedule is maintained and includes maintenance for internal and external areas, kitchen, laundry and clinical areas. Annual testing and tagging of electrical equipment have been completed and calibrations of medical equipment. Essential contractors are available 24 hours. Hot water temperatures in resident areas are monitored and are maintained within acceptable limits.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access the outdoor areas. Seating and shade are provided. The rest home rooms are spacious with ensuites. An additional two rest homes rooms were assessed as suitable for dual purpose beds. There is sufficient space for cares to be delivered and for the transfer of residents by hoist if required. There are call bells at the head of the bed and in the ensuites.</p> <p>The dementia unit has an indoor/outdoor flow with pathways and entry/exits into two courtyards with gardens shade and seating. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>The infection control coordinator (clinical manager) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at the combined quality meetings and the clinical meetings. Annual infection control reports are provided. Trends are identified, and preventative measures put in place. Internal audits for infection control including kitchen, cleaning and clinical care are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There were two outbreaks on 2019. Both were well managed, daily logs and communication with staff was maintained. Notifications were timely. Debrief meetings were held post each outbreak.</p> <p>There is a designated storage space (new initiative) provided for outbreak and disaster equipment and supplies. Nine trolleys have been purchased (three per 20 residents) and are available in each wing of the facility, excluding</p>

		the Dementia Unit where outbreak supplies are stored in a staff-only access room.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation of any restraint and enablers is reviewed through internal audits, RN and facility meetings. Interviews with the staff confirmed their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, there were two residents using bedrails as restraint and one resident enabler. The resident's file included the enabler, any risks associated with its use, and monthly review of the enabler. Two hourly checks were documented as charted. Staff have received training on restraint minimisation in June 2019 and the management of challenging behaviours in May and October 2019.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The service has continued to engage the Clown Doctors who have now had hours extended to visits the rest home residents. Resident records evidenced the positive effect the Clown Doctors have on the resident's wellbeing. The service has continued to initiate new activities as suggested by residents and families.</p>	<p>The Clown Doctors have been attending the hospital level residents and for the last two months the Clown Doctor hours on site have increased to visit the rest home residents. Over the last 18 months the same Clown Doctors have visited the residents and know them well. The Clown Doctors were present on the day of the unannounced audit. They were spontaneous, clever, funny and brought obvious joy to the residents who they greeted personally. Residents also enjoyed seeing the interaction between the Clown Doctors and the staff. The Clown Doctors visit fortnightly and maintain their own records on each resident visited. Currently they visit 50 residents each time they visit. They report any concerns they have about a resident's wellbeing to the RNs. A lady's group has been formed who enjoy going to gardens, shopping and out to cafés for lunch/coffee. The men's group have regular outings to the working man's club for lunches or a beer. Residents have suggested a day out to Orana park and they have commenced fundraising with their crafts to raise funds for those residents wishing to go on the outing.</p>

End of the report.