

# Oxford Court Lifecare Limited - Oxford Court Lifecare

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## 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 BSI Group New Zealand Ltd, 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:

<b>Legal entity:</b>	Oxford Court Lifecare Limited
<b>Premises audited:</b>	Oxford Court Lifecare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 28 January 2021      End date: 29 January 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	66

# Executive summary of the audit

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## 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	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	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

Oxford Court Lifecare provides care for up to 72 rest home and hospital residents. On the day of the audit there were 66 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, the GP and management.

The general manager (non-clinical) has been in her role for eight months. She is supported by the quality manager (manager of the sister facility) two care managers, an administration assistant, and experienced staff.

The service has addressed the previous partial provisional shortfalls around completion of the building, call bell installation, and the fire evacuation plan.

This surveillance audit identified shortfalls around wound interventions and documentation, and monitoring charts.

## 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.

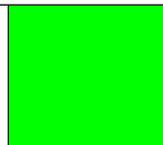


Standards applicable to this service fully attained.

The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). There is evidence that residents and family are kept informed. A system for managing complaints is in place, and a complaints register is maintained.

## Organisational management

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



Standards applicable to this service fully attained.

Oxford Court has a strategic plan and an annual quality and risk management programme that outlines objectives for the year and the internal audit programme and a health and safety programme which includes hazard management. Aspects of quality data including incident and accident data are reported at the various meetings. Oxford Court has comprehensive job descriptions for all positions. There is an annual in-service training programme and staff are supported to undertake external training. The service has a documented rationale for determining staffing levels and residents and relatives reported staffing levels are sufficient to meet resident 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Assessments, care plans and evaluations are completed by the registered nurses within the required timeframe. Care plans are written in a way that enables all staff to clearly follow their instructions. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. Meals are provided by an external company. Residents and relatives interviewed were complimentary about the food service.

## 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 has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. There is sufficient space to allow the movement of residents around the facility using mobility aids. The outdoor areas are safe and easily accessible for residents using mobility aids.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Oxford Court remain restraint free. No residents were using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Covid-19 was well planned for. Policies, procedures and the pandemic plan have been updated to include Covid-19. Adequate supplies of personal protective equipment were sighted.

## 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)
<b>Standards</b>	0	16	0	0	1	0	0
<b>Criteria</b>	0	45	0	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 complaint register is maintained by the general manager. There have been nine complaints (four in 2019 and five in 2020 and none to date in 2021) since the previous audit in February 2019. Verbal and written complaints are documented. All complaints have documented: investigation, timelines, corrective actions when required and resolutions. Results are fed back to complainants. The service has identified a corrective action around communication as a result of complaints which is being implemented.</p> <p>There is one complaint which has been lodged with the Health and Disability Commissioner which is ongoing. All evidence requested has been submitted and the service is awaiting the response at the time of the audit.</p> <p>Staff confirmed that complaints are discussed with them at staff meetings, and they notify RNs and/or the management if any residents and family members want to make a complaint. Interview with residents and relatives demonstrated an understanding of the complaints process and confirmed information around the complaints process is provided on admission.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Comprehensive information is provided at entry to residents and family/whānau. Four residents interviewed (two rest home, two hospital) stated that they were welcomed on entry and were given time and explanation about the services and procedures. The general manager and the two care managers were available to residents and relatives and they promote an open-door policy. Incident forms reviewed in January 2021 evidenced that relatives</p>

effectively with consumers and provide an environment conducive to effective communication.		had been notified on all occasions. Two hospital relatives interviewed advised that they are notified of incidents and when residents' health status changes promptly. The staff interviewed (two registered nurses, one enrolled nurse, one general manager, six caregivers, two activity coordinators), fluently described instances where relatives would be notified. Newsletters, emails and chats using 'WhatsApp' were utilised to keep relatives and residents connected and informed.
<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>Oxford Court Lifecare is privately owned and provides care for up to 72 rest home and hospital level residents. On the day there were 66 residents. There were 14 rest home level and 52 hospital including one resident on a Long-Term Support - Chronic Health contract (LTS-CHC).</p> <p>The facility is across two floors with lift access to the first floor. The 'new building' has been fully completed and opened in December 2019. There is currently one large double room which is shared by a married couple. The room has a full ensuite and has two call bells in place beside each bed. The double room capacity is included in the total number of residents. The general manager reported this room will only be used as a double room for married couples. Otherwise, the room will be single occupancy for a palliative resident.</p> <p>The interim general manager (non-clinical) has been in the role for eight months and is the regional manager for the company. She has a background in project management and has been involved in aged care for 3 years. She is supported by the facility manager from the sister facility who has a background in quality and risk management. They are supported by two care managers (both registered nurses) one for each floor. The care manager for the Reid unit has been in her role for 18 months and has worked for the company for 14 years. The care manager for the Maher unit has been in her role for 18 months and has experience in management. The general manager/regional manager meets with the directors frequently and provides a monthly report of clinical and non-clinical aspects of the facility.</p> <p>The facility has a five-year business plan, and an annual, quality and risk management plan which has specific annual quality goals identified that link to the strategic plan and are reviewed quarterly.</p> <p>The interim general manager has completed more than eight hours professional development, including a leadership and management day, district health board emergency management course, and attended the Covid-19 response meetings.</p> <p>The care managers have attended a medico legal forum, and study days through the district health board.</p>
Standard 1.2.3: Quality And Risk Management	FA	The annual quality plan for 2020/2021 has been implemented and is currently under review. An internal audit schedule is in place. Corrective actions have been developed where compliance is less than expected. Discussion of quality data is documented in the meeting minutes reviewed for staff, combined quality/health and safety/infection control, RN/clinical and resident meetings. Resident and relatives' meetings are held with follow-up of issues and

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>discussions documented. Interviews with the management team, registered nurses, and caregivers confirmed that the quality programme is implemented, and results are communicated to staff and relevant people.</p> <p>Resident surveys are conducted annually. The resident/relative survey was last conducted late in 2020, results were being collated at the time of the audit. Preliminary results evidence overall satisfaction, especially around the friendliness of staff. Lower satisfaction around answering of call bells. The 2019 satisfaction results evidenced a high level of satisfaction in the Reid unit with all aspects of activities (time, variety, frequency), and care. The Maher unit satisfaction results evidenced a high satisfaction around all the variety of activities, and the environment. Corrective actions were implemented in areas of lower satisfaction. A separate food services audit is completed which evidenced overall satisfaction.</p> <p>The interim general manager is the health and safety officer and has completed health and safety training around workplace safety. The health and safety committee (quality committee) are representative from all departments. Oxford Court collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. A health and safety component is included in the annual competencies which staff complete and is part of the orientation of new staff. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and was last updated in March 2020. The general manager reported an average 33% staff turnover in 2020.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>Accidents and near misses are investigated by the care managers who analyse data for trending. There is a discussion of incidents/accidents at monthly staff meetings, health and safety/IC/quality meetings and RN/clinical meetings, including actions to minimise recurrence. Ten incident forms (five hospital and five rest home) sampled from January 2021 document clinical follow-up of residents is conducted by a registered nurse. The electronic event forms have a section to indicate if family have been informed (or not) of an incident/accident, and these were fully completed, and the reason was documented if the notification did not occur. Neurological observations were completed for all un-witnessed falls. Opportunities to minimise future risks (where possible) were identified and implemented.</p> <p>Interviews with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been a total of five section 31 notifications reported since the last audit for pressure injuries of stage 3 or higher.</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>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation, staff training and development to guide management to ensure that appropriate people are recruited to vacant positions.</p> <p>Five staff files were reviewed (one care manager, one RN, two caregivers, and one kitchen hand). All had relevant documentation relating to employment, and relevant checks were completed to validate individual qualifications and experience. All had annual performance appraisals.</p> <p>Oxford Court has an orientation programme in place that provides new staff with relevant information for safe work practice. There is an education plan that is being implemented that covers all contractual education topics and exceeds eight hours annually. The care managers and registered nurses can attend external training including sessions provided by the local DHB. A competency programme is in place that includes annual medication competency for staff administering medications. There is a minimum of one staff member with a current first aid certificate on every shift. A record of practising certificates is maintained.</p> <p>There are 10 registered nurses (including the two clinical managers) and two enrolled nurses employed at Oxford Court. Six registered nurses, one care manager, and one enrolled nurse are interRAI trained.</p> <p>Interviews with the facility manager reported staff are encouraged to complete New Zealand Qualification Authority (NZQA) through Careerforce. There are currently nine caregivers with level 4, 13 caregivers with level 3, and ten care givers with level 2 NZQA.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There are a total of 60 permanent staff and a pool of casual staff. Sufficient staff are rostered on duty to manage the care requirements of the residents. The general manager and care managers work full-time Monday to Friday. The care managers share on call after hours.</p> <p>In the Reid wing, 36 beds - 34 residents (28 hospital level residents including the resident in LTS-CHC, and six rest home level). A registered nurse is rostered on each shift.</p> <p>In the Maher wing 36 beds – 32 residents (24 hospital and eight rest home). A registered nurse is rostered on all shifts. Enrolled nurses work four days on, two days off. Enrolled nurses are rostered with registered nurses on the evening and night shifts.</p> <p>Each wing has six caregivers on the morning shift; 1x 6.45 am to 3 pm, 1x 7 am to 3 pm, 1x 7 am to 2.30 pm, 1x 7 am to 2 pm, 1x 7 am to 1.30 pm and 1x 8 am to 4 pm.</p> <p>The afternoon shift has five caregivers; 1x 2.30 pm to 11 pm, 1x 3 pm to 10.30 pm, 1x 3.30 am to 9.30 pm, and 2x 4 pm to 9.30 pm.</p> <p>The nightshift is covered by three caregivers a registered nurse and an enrolled nurse from 10.45 pm to 7 am.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of</p>

		residents.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. The 12 medication charts sampled were documented correctly by medical practitioners and there was evidence of three-monthly reviews by the GP.</p> <p>Medication prescribed was signed as administered on the electronic medication management system. All staff that administer medication are competent and have received medication management training. The facility uses a robotics pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. There were two residents self-administering inhalers; medication competencies were sighted and have been reviewed. Medication fridge and room temperatures were recorded and were within expected ranges. The medication room in the 'new build' is fully functional and secure, and the medication trolley is lockable. The previous shortfall from the partial provisional has been addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is an external contractor providing the food services for Oxford Court. The contractor has a Food Control plan expiring November 2021. The external contractor conducts audits as part of their food safety programme. Fridge and freezer temperatures are electronically monitored and recorded daily in the kitchen. Food in the fridge and freezers was covered and dated. Special or modified diets are catered for. Soft and puree dietary needs are documented in files sampled. This includes consideration of any particular dietary needs (including cultural needs). A dietary assessment is made by the RN as part of the assessment process, and this includes likes and dislikes. One copy is sent to the catering contractor, and one copy remains in the onsite kitchen.</p> <p>Food is plated in the kitchen and transported to each dining area via hot boxes. The meals in the main dining room (adjacent to the kitchen) are served from the bain marie from the kitchen servery. Kitchenhands record the temperature of hot and cold dishes prior to serving. The kitchenhand interviewed was knowledgeable and could easily describe processes of heating meals and recording food temperatures in the electronic app. Resident and families interviewed were complimentary of the food service. There was evidence of residents receiving supplements.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive</p>	PA Moderate	<p>When a resident's condition changes, the registered nurse, or care manager initiates a review and if required, a GP or nurse specialist consultation. There was documented evidence in the resident files of relatives' notification of any changes to health including infections, accidents/incidents and medication changes. Residents interviewed stated that their needs are being met. Relatives interviewed stated that their relative's needs are met, and they are kept</p>

<p>adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>informed of any health changes.</p> <p>Staff have access to sufficient dressing supplies. On the day of the audit, there were six residents with superficial stage 2 pressure injuries, and one resident with an unstageable pressure injury on a heel. A section 31 notification was sighted for this wound. Incident reports were completed for all pressure injuries, and all wounds related to falls.</p> <p>There were two rest home level residents with skin tears, and seven residents with wounds (including two residents with three wounds). Wounds included chronic ulcers, skin tears and a blister, and a necrotic toe (illness related). Electronic wound assessment, plans and evaluations were in place for current wounds, however one chart had more than one wound documented. All short-term wounds were documented on a short-term care plan, long-term care plans contained interventions for the chronic wounds. The registered nurses and care managers have access to the district health board (DHB) specialist wound care service. The wound care specialist has been involved with residents with chronic ulcers and the unstageable pressure injury.</p> <p>Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>There is a suite of monitoring charts on the electronic system including, (but not limited to), food and fluid charts, weight, observations, behaviour, and wound monitoring.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A diversional therapist and an activities coordinator are both employed for 28 hours per week and between them cover Monday to Saturday 9.45 am to 5.00 pm. The activities team provide a varied programme designed to meet the needs of the rest home and hospital residents. Both the diversional therapist and the activities assistant have current first aid certificates.</p> <p>Each resident and/or relative completes a social profile to include all past interests and hobbies of residents. Information gleaned from the social profile is included in the electronic social and recreational care plan. A list of interests and hobbies of all residents is maintained, which provides ideas for the activity planner. The activities team maintain at least three-monthly reviews, which evidenced a reflection of progression towards meeting or reviewing residents' goals. Each resident is free to choose whether they wish to participate in the group activities programme. Daily participation records and progress notes are maintained. Group activities are held in the large lounge on the ground floor, and include group games, entertainers and housie. Celebrations and special days are celebrated. The activities team is planning a beach day with a barbeque and beach/Hawaii theme. The residents participate in crafts in line with the theme, residents have been making wreathes for head wear, and a decorated photo frame. A gardening group has been developed. Resident meetings are held regularly and provide an 'open floor' for feedback and suggestions for the programme and outing destinations. Meeting minutes evidence a fairly high attendance rate. Community activities include visits from the Blind Foundation and Age Concern. An interdenominational church service is held monthly. Entertainers are scheduled twice monthly. Residents and relatives interviewed spoke positively about the activities.</p>

		During the Covid-19 lockdown residents were encouraged to maintain contact with relatives via 'WhatsApp', phone calls and regular emails were sent to the relatives from the management team. The activities continued as far as possible and included more one-on-one activities. Individual packs were provided for residents to include puzzles and hand gel.
Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Initial care plans, interRAI assessments, short-term care and long-term care plans were evaluated/reviewed in a comprehensive and timely manner. Reviews were fully documented and included current resident's status, any changes and achievements towards goals. Family/whānau, residents and staff input is obtained in all aspects of care.  Short-term needs care plans are developed for acute needs. Social and recreational plans are reviewed as part of the residents' care plan reviews. The GP and nurse practitioner complete three-monthly medical reviews.
Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building warrant of fitness expired in September 2020. Due to the Covid-19 lockdown, the essential checks could not be carried out, therefore a certificate 12s form is in place. A letter from the Dunedin City Council explains the 12a form cannot be displayed, however, "understands that the systems within the building are fully operational". The letter goes on to explain that the contractor will continue to carry out inspections for the next 12 months, so a building warrant of fitness can be produced in 2021.  The new building was opened in December 2019. The sluice room is fully functional. Hot water temperatures are checked monthly with the rest of the facility. The previous shortfalls at the partial provisional have been addressed.  The maintenance person interviewed described the preventative and reactive maintenance schedules (sighted) and the random testing of the hot water temperatures. The hot water temperatures were all within expected ranges. Essential contractors are available after hours if required.  All communal areas around the facility are easy for residents to access using mobility aids. Corridors are wide, ramps provide access to different levels of the ground floor, and there is lift access to the first floor. Outdoor areas are well maintained and provide seating and shade. New courtyard areas have been developed and are fully landscaped, complete with seating and shade.  Staff interviewed reported they have sufficient equipment to carry out resident cares.
Standard 1.4.7: Essential, Emergency, And	FA	There is an emergency management plan/manual in place. Fire evacuation drills are held at least six-monthly. The civil defence kit is readily accessible in designated storage cupboards. The kit includes an up-to-date register of all residents' details. The facility is prepared for civil emergencies and has emergency lighting and BBQs. An

<p>Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>emergency food and water supply, sufficient for three days, is maintained. Extra blankets are also available. Hoists have battery packs and there are batteries that can be used to operate electric beds in the event of a power failure. There is a list of names and contact details of staff so that they can easily be contacted in an emergency. There is an approved fire evacuation scheme dated 20 June 2019. Call bells are in place and the system has been activated. The shortfall from the partial provisional audit has been addressed.</p> <p>The facility is secured during the hours of darkness. Staff are security conscious. Appropriate training, information, and equipment for responding to emergencies is provided. The call bell system is available in all areas and there are indicator panels in each area. During the tour of the facility, residents were observed to have easy access to the call bells. Residents were observed to have sensor mats in place. Residents interviewed stated that their bells are answered promptly.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. The registered nurse enters all infections on to the electronic system, which generates a monthly report. Graphs are placed in the staffroom for staff to read. Infection data, outcomes and corrective actions are discussed at the facility meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the care managers and the general manager.</p> <p>Since the previous audit, there has been one outbreak in July 2019. Logs were maintained, staff were kept informed, and the public health team were notified and kept informed.</p> <p>Covid-19</p> <p>The infection control policies, protocols, the infection control programme, and the pandemic plan have been updated to reflect Covid-19. The registered nurses are aware of protocol at each stage of lockdown, resources are readily available. Extra training was provided around personal protective equipment, isolation protocols and a questionnaire was answered by all staff around Covid-19. Findings were discussed at staff meetings. Staff were updated via the rostering system, and newsletters were provided for relatives updating them of the activities programme and new guidelines as they were available. There were no recommendations following the DHB Covid-19 audit. Adequate supplies of personal protective equipment were sighted.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service continues to be restraint free, and there were no residents using enablers. An electronic register is available.</p> <p>The restraint coordinator (Reid care manager/ RN) confirmed the use of enablers/restraint is discussed at the monthly combined quality/health and safety/infection control meetings, and staff meetings. Restraint use is included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education is</p>

minimised.		provided.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Long term and short-term care plans were in place to guide caregivers on acute needs of the residents. These were sighted for infections, skin tears, and recently diagnosed pressure injuries, however, they did not always reflect all of the interventions for caregivers to follow. All current wounds had a wound care assessment, plan and evaluation' however these were not always documented correctly. Monitoring charts were sighted for challenging behaviour, and intentional rounding; however, these were not in place for all acute needs of residents. Photos are taken on a regular basis and scanned into the electronic system to identify progression or deterioration of the wound.</p>	<p>i) There was no monitoring chart for a hospital resident with unintentional weight loss and another with a pressure injury.</p> <p>ii) There were no pressure relieving/prevention strategies documented on the care plan for a hospital resident with a current</p>	<p>i) Ensure monitoring charts are completed for residents with unintentional weight loss.</p> <p>ii) Ensure all pressure relieving strategies are included in the care plans for residents with</p>

			<p>pressure injury.</p> <p>iii) Three wounds were documented on the same chart for a hospital level resident.</p> <p>iv) One wound was not classified correctly for a hospital level resident.</p>	<p>current pressure injuries, and residents at risk of developing a pressure injury.</p> <p>iii) Ensure all wounds have individual wound care assessments, plans and evaluations completed.</p> <p>iv) Ensure all wounds are classified correctly.</p> <p>60 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.