Oceania Care Company Limited - Takanini Lodge

Introduction

This report records the results of a Partial Provisional 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 The DAA Group 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:	Takanini Lodge
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: 27 July 2021 End date: 27 July 2021

Proposed changes to current services (if any): Reconfiguration of beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 87

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.

General overview of the audit

Takanini Lodge provides rest home, hospital and dementia level care for up to 90 residents. The service is owned and operated by Oceania Healthcare Limited and managed by a business care manager (BCM) and a clinical manager.

This partial provisional audit was conducted to confirm the configuration and use of the facility's 90 beds. The service provider seeks to reduce the number of rest home beds from 21 to 12 by reconfiguring nine beds to hospital level care and designating all hospital beds as dual purpose beds. There will be no impact as all of the beds, apart from the 21 dementia beds, had already been assumed to be dual purpose The total number of beds will remain the same (90) with the final designation being; 57 hospital/dual purpose beds, 12 rest home beds and 21 dementia beds.

The audit was conducted against a subset of the Health and Disability Services Standards and the service's contract with the district health board (DHB). It included visual inspection of the rooms identified for dual purpose use, review of applicable policies and procedures, review of staff files, observations and interviews with management and care staff, allied health staff, family members, and current residents.

This audit resulted in no changes being required.

Consumer rights

Not applicable to this audit.

Organisational management

The reconfiguration of beds will not impact the well-established systems in place for governance, managing services, or the recruitment, training and performance management and allocation of staff.

The staffing formula already demonstrates there are sufficient numbers of clinical and auxiliary staff allocated on all shifts, seven days a week, to meet the needs of all residents. The allocation of registered nurses (RNs) across the site 24 hours a day seven days a week (24/7) more than meets contractual requirements.

Continuum of service delivery

Appropriate systems for the safe delivery of medicines are installed. Medicines are only administered by staff who have been assessed as competent to do so.

Food services are regularly reviewed to ensure they meet the nutritional needs of potentially more mobile residents. Individual and special needs are catered for. The home has a reputation for and history of safe food management. Current residents and families confirmed a high level of satisfaction with meals.

Safe and appropriate environment

All aspects of the home meet the needs of residents. The environment was clean, and internal and external areas were being well maintained. There was a current building warrant of fitness. Electrical and medical equipment is checked and tested as required. Communal and individual spaces were maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken offsite and evaluated for effectiveness.

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

Restraint minimisation and safe practice

Not applicable to this audit.

Infection prevention and control

The infection prevention and control programme, led by an experienced and trained infection control coordinator, was succeeding at preventing and managing infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	0	0	0	0
Criteria	0	35	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Takanini Lodge is an Oceania aged-care residential care facility. Day to day services are managed by a facility BCM with support from a CM who oversees clinical care. Both managers are registered nurse with current practising certificates. The onsite team are supported by a regional operations manager and a regional care manager (RCM) who was on-site and interviewed during this audit. The RCM routinely visits the facility in addition to providing regular remote support. This person was observed assisting the BCM and CM during the audit and demonstrated in depth knowledge of the service including its history and trends in service delivery. It was stated that of the 14 aged care facilities in the region, Takanini Lodge had the most stable cover of RNs with a very good back up of casual/pool nurses. The BCM has been in the role since 2017 having been employed by Oceania as a CM for six years. A senior RN who had been working at Takanini Lodge for five years, was acting CM on the day of the audit and had been in the role for four weeks. The secondment is for a fixed term. The BCM acknowledged their accountability for the implementation of quality

		improvements and appropriate services delivery by the facility. This person submits monthly reports on a range of business and clinical performance indicators. The data is collated at a national level and provided on dashboards to the regional teams who report to the executive management team and Oceania Healthcare board. The service has an aged residential care contract (ARCC) with Counties Manukau DHB for the provision of hospital, rest home, and dementia level care, which includes primary options for acute care (POAC), respite/short term care and long-term support-chronic health conditions (LTS-CHC). On the day of this audit, there were 87 residents on site; 15 were receiving rest home level care, 51 receiving hospital level care, and 21 receiving dementia level care. Five residents were under the age of 65 years under the LTS CHC agreement.
Standard 1.2.2: Service Management 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.	FA	As per Oceania policy, the BCM delegates their management responsibilities to the long acting administrator and CM with day to day support from the RCM during any temporary absence. Cover for the CM's absence is allocated to a senior RN under the BCMs supervision. The RCM who is also an RN with a practising certificate said they would organise a qualified relief manager from the Oceania group to cover any prolonged absence of the BCM.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. There was recorded evidence of staff receiving an orientation specific to their roles with a generic induction component. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period. Staff education is planned by the national clinical education team on an annual basis and includes mandatory training topics. This provides a minimum eight

		hours of professional development for nurses, other clinical and non-clinical staff as required by regulations and contractual requirements. The scheduled education and regular competency assessment programme reflects the skills and knowledge required for the care of older residents, those that are under 65 years of age and people receiving dementia care. Interviews and documentation sighted confirmed that each of the 17 HCAs working in the dementia care area had completed the Limited Career Pathway (LCP) – dementia series module 4, which incorporates unit standards 23920, 23921, 23922, 23923, as required by contract. Oceania policy is to only appoint care staff who have completed at least level 2 of The National Certificate in Health and Wellbeing to meet the requirements of the provider's agreement with the DHB Of the 55 health care assistants (HCAs) employed, 38 have completed level 4, 13 are at level 3 and four are at level 2. There are two staff members who are internal assessors for the programme. Of the 16 RNs employed at Takanini Lodge, 14 are trained and maintaining their annual competency requirements to undertake interRAI assessments. Annual performance appraisals were sighted in all staff files reviewed. The service provider demonstrated that the current systems for recruitment and management of staff is suitable for the provision of up to 57 hospital level care residents. No changes are required as a result of this partial provisional audit.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The organisation has a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels are readily adjusted to meet the changing needs of residents. Observations and review of a four-week roster cycle confirmed this meets contractual requirements and that adequate staff cover has been provided, with staff replaced in any unplanned absence. The RCM stated that Takanini Lodge had the most stable cover of RNs with a very good back up of casual/pool nurses. The facility seldom uses bureau staff. The BCM and CM are rostered on call after hours, and staff reported that good

		access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Extra nursing support is provided Wednesday to Sunday in the midday period to help with nursing administrative tasks and routine communication with the multidisciplinary team (MDT and families. At least one staff with a current first aid certificate is allocated to each wing of the facility across all shifts. Seven days a week, there are at least two RNs in the two mixed hospital/rest-home wings on the morning and afternoon shifts, and there is one RN at night across both wings. Twelve HCAs with a mix of long and short shifts are rostered in the morning in those two wings; seven in the afternoon, and two HCAs at night do a full shift. The dementia unit has one RN and two HCAs in the morning, plus an activities person from 11am to 5.30pm seven days a week. There are two HCAs in the afternoon, and two HCAs at night. The RNs posted in the hospital/rest-home wings provide assistance to the dementia unit in the evening and at night as required. Families and residents said they were satisfied with the availability of staff at all times. There were no changes required to the current systems for determining staff availability as a result of this partial provisional audit.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Medicines were being managed safely and stored securely to meet legislation, protocols and guidelines. All medicine related incidents or errors are reported, risk rated and reviewed immediately by senior management to identify cause and implement actions to prevent recurrence. There had been one low risk error reported to date this calendar year. Takanini Lodge uses an electronic system for medicines prescribing and administration. The CM utilises reports in the electronic medicine management system to monitor adherence to safe medicines management. Interview with the CM and review of medication records verified that information

		meets legislative requirements and guidelines. Individuals are accurately identified, and their allergies and sensitivities were documented. Medication records were reviewed by the GP at three-monthly intervals or when the health needs of the resident changed to an extent that their prescribed medicines required review. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided six monthly or more frequently on request. Controlled drugs are stored securely in accordance with legislative requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Medicine balances reviewed were correct. Registered nurses and senior HCA responsible for medicines management complete annual competency testing and education. Safe medicine management practice was observed during the lunch time medication rounds. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. At the time of audit there were no residents self-administering. Standing orders were not in use at this facility. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. There were no stored vaccines or evidence of cold chain accreditation. A number of RNs are trained as vaccinators and the CM is aware of the requirement for cold chain accreditation. Interview with the CM and review of records evidenced antimicrobial policy meets accepted guidelines, monitoring and compliance is maintained and any trends are reported at health and safety meetings. As stated above, there is an implemented process for comprehensive analysis of any medication errors. The medication system and practices will not be impacted by the reconfiguration of beds. No changes were required as a result of this audit.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Food services and provided on site by an experienced and qualified chef and kitchen team. All kitchen staff have completed education in safe food handling. The menus were in line with recognised nutritional guidelines for older people and follow summer and winter patterns. These continue to be reviewed by the Oceania team of qualified dietitians six monthly, at each change of season. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by JAZ-ANZ which expires on 4 January 2023. Evidence was sighted that action had been taken within days to resolve the one recommendation issued by the verifier during the June 2020 assessment. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the dementia unit have access to food and fluids to meet their nutritional needs at all times. Sufficient special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and in resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Food services will not be impacted by the reconfiguration of beds. No changes were required as a result of this audit.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during	FA	The organisation has current policies and procedures which clearly describe disposal methods for all types of human and domestic waste. These included standards about chemical labelling, the use of protective clothing and equipment and reporting of spills incidents. Sluice rooms were observed to be in a tidy and hygienic condition. Chemical Material Safety Data sheets were available and

service delivery.		readily accessible to staff in several locations. The sighted hazard register was current and reported to be updated each month at the health and safety meetings. Review of staff training records and interviews with staff who carry out cleaning confirmed that regular training and education on the safe and appropriate handling of chemicals and waste occurs. Visual inspection throughout the facility and observations of staff revealed that protective clothing (PPE) and equipment (for example, gloves, plastic aprons, footwear, and masks) is provided. The service is maintaining at least one additional week's supply of PPE. All chemicals were being stored securely and decanted into clearly labelled containers. The chemical supply company visits each month to check the effectiveness of their products and to support staff with correct handling and use of chemicals.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness, expiry 14 February 2022, was displayed in the entrance to the facility. Buildings, plant, and equipment comply with relevant legislation. A preventative and reactive maintenance schedule is implemented. This includes monthly maintenance checks of all areas and specified equipment such as hoists. Requests for repairs or maintenance issues are documented and reviewed daily by maintenance personnel who attended to these promptly. This was confirmed by review of maintenance log sheets and staff who said repairs were conducted in a timely manner. Interviews with staff and visual inspection confirmed there is adequate equipment available to support care. Testing and tagging of electrical equipment occurred in January 2021. Evidence of checking and calibration of biomedical equipment, such as hoists was sighted. There is a system to ensure that the facility van that is used for residents' outings is routinely maintained. Inspection confirmed that the van has a current registration, warrant of fitness, first aid kit, fire extinguisher and functioning hoist. Staff interviews and documentation evidenced that those staff who drive the van have a driver's licence and complete van driving and competency assessments. Hot water is tested monthly to ensure this is delivered are at a comfortable and

		safe temperature, no higher than 45 degrees Celsius or 60 degrees in utility areas. All resident areas allow safe and easily access with or without mobility aides. External courtyards and decks have outdoor seating and shade. The dementia unit has a secure internal courtyard which can be accessed freely by residents and their visitors.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There were sufficient numbers of accessible bathrooms, resident, visitors' and staff toilet facilities throughout the facility. These all had call bells and were of a sufficient size to facilitate ease of mobility and to promote independence. Six communal toilets and five showers including a bed shower room were located within close proximity to the nine bedrooms that were being assessed as suitable for hospital level care. Appropriately secured and approved handrails were installed in each of the toilet/shower areas, and other equipment/accessories were available to promote residents' independence. Communal toilets had a system to indicate vacancy and have disability access. Residents were observed being supported to access common area showers in a manner that was respectful and maintained their dignity.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Close inspection of the nine bedrooms identified for reconfiguring to dual purpose use, confirmed there was adequate space to allow use of a hoist and to enable residents and staff to move around safely. These all measured at least nine square metres with one room measuring 11 square metres. Each of these bedrooms provided for single accommodation. Residents and families confirmed they could personalise the residents' bedrooms with furnishings, photos and memorabilia of their choosing. There were additional areas to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. This audit confirmed the bedrooms spaces as suitable for hospital level care.

Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Plenty of communal areas, including five lounge areas and a number of small nooks with seating were available throughout the facility for use by residents and their visitors. Two lounges and the main dining room were within easy distance from the wing where the nine bedrooms identified for dual use were located. These areas are used for socialisation, and activities in addition to another very large activities lounge. All internal communal areas were spacious, furnished appropriately and had external views. Observation and interviews with residents and family confirmed there were ample areas available for privacy when required, and that the accommodation meets residents' needs. There were additional areas for storing activities equipment and resources. Most residents were observed to have their meals with other residents in the communal dining rooms but can have their meal in their own room if they wish. No changes were required to the current set up for dining, recreation and activities as these could easily incorporate more hospital level care residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundry services, including residents' personal clothing, is completed off-site at another Oceania facility. Colour coded, covered laundry trolleys and bags were observed to be used for transport. There is one laundry assistant on morning and evening duties seven days a week, who is responsible for unpacking, sorting and delivering laundry to residents. Interviews confirmed that duties were confined to laundry functions only. Household staff interviewed confirmed knowledge of their role including management of any infectious linen. There was clear delineation for dirty entry and clean exit in the laundry area. A domestic washing machine and dryer is on site for use when required. Two cleaners are on duty each day from 7am to 1.30pm seven days a week. Cleaning duties and procedures are documented to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. There are designated locked cupboards for the safe and hygienic storage of cleaning equipment and chemicals. The cleaner stores chemicals on a trolley when cleaning and interview and observation confirmed awareness of the need to keep the trolley with them at all times.

		Staff receive training in correct use of cleaning products. There are sluice rooms available for the disposal of soiled water/waste. Hand washing facilities were available throughout the facility with sanitizing hand gels in various locations. The effectiveness of cleaning and laundry processes are monitored through the internal audit process with no significant problems identified. Resident and family interviews, resident surveys and observations confirmed that cleaning and laundry services will not be impacted by any increase in the number of hospital level care residents.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the Fire Service New Zealand in 2018 and there has been no change to the physical layout of the building. Smoke detectors, sprinklers and other equipment was installed throughout the building. Fire suppression systems including fire alarms, safe egress and evacuation signage is checked monthly by an external company. Trial evacuations were occurring every six months the most recent being on 21 July 2021. A copy of the evacuation report is sent to the Fire and Emergency Services, New Zealand (FENZ). These were sighted and showed no issues. Each of the four wings within the building containing 20 or 21 residents, is designed to be its own fire cell. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. All RNs and the health and safety representative receive first aid training so there are at least two staff members on each shift with a current first aid certificate. Alternative energy and utility sources are available in the event of the main supplies failing. These include a port for an externally sourced generator, battery operated emergency lighting and gas BBQ's. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones, radios, and continence supplies were sighted and meet the National Emergency Management Agency recommendations for the region. A large water storage tank is located in the grounds and emergency and pandemic supplies are

		checked monthly by the CM. The service's emergency plan includes considerations of all levels of resident need including those of YPD. A functional call system is installed with easy to reach call buttons located in bedrooms, bathrooms and communal areas. Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. There are effective security systems for the protection and safety of residents, visitors and staff. These include visitors signing in and out, automatic locking of the facility at 7pm, an intercom for after-hours access and night-time security lighting. Monitored security cameras are positioned in the corridors and external doors. RNs are alerted to the opening of emergency doors via their pagers. There have been no security incidents since the facility opened in 2018. The requested change in the number of hospital residents will not significantly impact the current emergency and security systems.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas accessed by residents have safe ventilation and at least one external, opening window of sufficient size for natural light and ventilation. One of the nine bedrooms inspected had an external door which opened onto a small patio area. Heating is provided by a combination of heat pumps and high mounted wall panel heaters. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. Systems are in place to obtain feedback on the comfort and temperature of the environment. No changes were required as a result of this partial provisional audit.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and	FA	The service is maintaining an infection prevention and control (IPC) programme which minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, and a clinical nurse lead who is the nominated IPC coordinator, with oversight from the clinical manager. This role and responsibilities are defined in a

scope of the service.		job description. The IPC coordinator and CM attend regular external training on the principles and practices of infection, prevention and control. The infection control programme and manual is reviewed annually and was updated in December 2020. Infection control matters, including surveillance results, are reported monthly to the IPC committee. The committee comprises the IPC coordinator, BCM, CM, a health and safety representative, the chef, the maintenance person, a diversional therapist (DT), a cleaner and laundry person and an HCA representative. Signage at the main entrance requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. Takanini Lodge notified a suspected outbreak of scabies on 09 February 2021. The event was limited to four residents and was resolved quickly by 25 February 2021. Suitable quantities of appropriate equipment and resources such as gloves, masks, gowns and portable hand sanitising lotion were in place. The proposed reconfiguration of beds will not impact on the systems for minimising and preventing infections already in place.

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.

No data to display

End of the report.