

Glenhays Limited - Southanjer

Introduction

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

The audit has been conducted by 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: Glenhays Limited

Premises audited: Southanjer

Services audited: Dementia care

Dates of audit: Start date: 22 February 2022 End date: 23 February 2022

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 22

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

Southanjer provides dementia rest home level care for up to 24 residents. Located in a semi-rural setting on the outskirts of Oamaru, the service is operated by Glenhays Limited and managed by a facility manager who is also a shareholder of the entity. Families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards (2008) and the service's contract with the Otago District Health Board and the Ministry of Health. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, the facility manager, staff, and a general practitioner.

This audit has resulted in a continuous improvement rating in relation to the 'Our backyard project', staff culture and engagement and a falls minimisation project. There are no areas requiring 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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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Southanjer when they are admitted. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

Services at Southanjer are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

Care for any residents who identify as Māori is guided by a comprehensive Māori health plan and related policies.


There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required and bi-lingual staff.

Southanjer has linkages to a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

Information about the complaints process is provided at the time of admission and is available at the front entrance. Complaints are being fully investigated and responded to. 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.
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A business and quality and risk management plan is in place and includes the goals and values of the organisation. Monitoring of the services provided to the governing body was regular and effective. The manager is a practising physiotherapist and has overseen the organisation for the past five years.

The quality and risk management system includes collection and analysis of quality improvement and trending data to support improvement, including several quality-of-life initiatives. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented from audits and events or where improvement is needed. Staff are fully involved with residents and families, with feedback actively sought and acted upon. Actual and potential risks, including health and safety risks, are identified, and mitigated. Policies and procedures support service delivery to residents. These were current, comprehensive, and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents. There is a small casual pool of staff, some of whom work across this and a sister site.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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.
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Residents' admissions to the facility is appropriate and efficiently managed with liaison evident between the Needs Assessment Service Co-ordinator (NASC) service and the clinical team. Relevant information is provided to the potential resident's enduring power of attorney (EPOA) to facilitate admission to the facility.

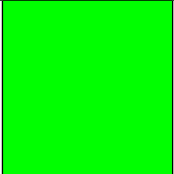
The residents' needs are assessed by the multidisciplinary team on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information, and accommodate any new problems that might arise. The residents' files reviewed evidenced that the care provided, and the needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health providers as required. Shift handovers and communication sheets promote continuity of care between the shifts.

One part time diversional therapist and two part time activities assistants deliver the planned activity programme over seven days. The activities programme provides a variety of individual one on one time and group activities whilst maintaining the residents' links with the community. There is a facility van available for outings.

Medicines are managed according to the policies and procedures which are based on current best practice and consistently implemented. Medications are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with any special requirements catered for. There is a selection of food available for residents 24 hours a day. Policies guide the food service delivery supported by a chef with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents and families verified satisfaction with the meals provided.

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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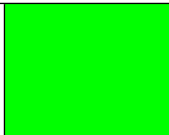
The facility meets the needs of residents and was clean and well maintained, including recent environmental upgrades. There was a current building warrant of fitness. Electrical and biomedical equipment has been tested as required. Communal and individual

spaces are maintained at a comfortable temperature. There are rural views, outdoor spaces are accessible, safe and provide shade and seating for residents.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing appropriately. Chemicals, soiled linen, and equipment are safely stored. Laundry is undertaken onsite and monitored 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. A new call bell system has been installed and staff were observed to promptly respond. Security is maintained.

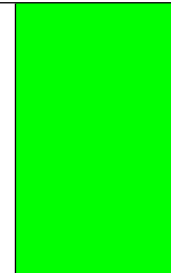
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers or restraints were in use at the time of audit, and none have been used for several years. Use of enablers is voluntary for the safety of residents who require these. Staff have received training and demonstrated a sound knowledge and understanding of the restraint and enabler process.

Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse and aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

Staff demonstrated good knowledge around the principals and practice of infection control, guided by relevant policies and supported with regular education.

Age care specific infection surveillance is undertaken, with data analysed, benchmarked and results reported through to all levels of the organisation. Follow up action is taken as and when required.

Covid-19 related processes are in place to manage the changes in the Ministry of Health Covid-19 response levels.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	44	0	0	0	0	0
Criteria	3	90	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Southanjer has policies, procedures, and processes in place to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). This is displayed throughout the facility in both English and Māori, and there is a copy of this in the admission pack. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is compulsory for all staff as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and</p>	FA	<p>Nursing and care staff interviewed understood the principals and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs and outings. Advanced care planning, establishing, and documenting enduring power of attorney requirements and processes for residents is defined and documented, as relevant, in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>All residents' files reviewed had an enduring power of attorney (EPOA) in place and these have been activated. There were no residents in the secure unit with English as a second language. Several staff are bi-</p>

give informed consent.		lingual and interpreter services are available if required. All families were well informed as per the family communication sheets, incident forms and interviews reviewed. Staff were observed gaining consent for day-to-day care on an ongoing basis
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents' family/whanau are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display in the reception area of the facility. Family members were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff are also aware of how to access the Advocacy Service if this is required.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family/whanau and the community by attending a variety of organised outings, visits, activities, and entertainment as current COVID-19 restrictions allow. The facility encourages visits from family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their engagement with the staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided in the admission pack and at the entrance to the facility. Those interviewed knew how to do so. The completed complaint form is given to the RN or manager, who considers the complaint and instigates any immediate action necessary. As part of the complaint process and policy, acknowledgement is sent to complainant.</p> <p>The complaints register reviewed showed that three complaints had been received over the past year and that actions taken, through to an agreed resolution, were documented and completed within the expected timeframes. Action plans showed any required follow up and improvements have been made where possible. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit, including Health and Disability Commissioner complaints.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>When interviewed, the family/whanau of Southanjer residents, reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. Information on how to make a complaint and provide feedback is available and displayed in the reception area.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and their families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understand the need to maintain privacy and were observed doing so throughout the audit when attending to the personal cares of residents, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families. All residents have a private room with communal lounge and dining room facilities there are no rooms with private ensuites. Several lounges are located throughout the facility providing quiet areas to chat away from the main communal areas.</p> <p>Residents are encouraged to maintain their independence by participating in activities within the facility and with visiting community entertainers as COVID allows. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs have been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to be occurring during the orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There were no residents at Southanjer who identify as Māori at the time of audit. Staff receive annual education to enable them to support residents who do identify as Māori to integrate their cultural values and beliefs. The principals of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whanau. There is a current Māori health plan and guidance on tikanga best practice is available and there are staff who identify as Māori.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents' families verified that they were consulted on their family/whanau member's individual culture, values and beliefs and that staff respected these. Residents' personal preferences required interventions and special needs were included in all care plans that were reviewed. For example, likes and dislikes and attention to preferences around activities and dietary preferences. Residents' families/whanau survey results evidenced that the residents' needs are being met.</p> <p>Staff can access an external interpreter service for residents if required and several staff members are bi-lingual.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. The general practitioner who was interviewed also expressed satisfaction with the standard of services provided to the residents. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service provides and encourages good practice. This is demonstrated through evidence-based policies, input from external specialist services and allied health professionals, district nurses, dieticians, and education for staff. The GP confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. A continuous improvement rating has been put forward for criterion 1.3.6.1 relating to a reduction in falls.</p> <p>Staff reported that they receive management support for external education and access their own professional networks.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family/whanau stated they were kept well informed about any changes to their relative's status, they were advised in a timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' records reviewed. There was also evidence of family input into the care planning process and the multi-disciplinary meetings. Staff understood the principals of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff knew how to access an interpreter should this be required, and several staff members are bi-lingual.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans (January 2022) are reviewed annually. These outline the purpose, direction and goals of the organisation focused on 'our family' (residents, whānau and the care team) to have the best quality of life and to get the best out of life with a family centred approach. The documents described annual and longer-term objectives and the associated operational plans, with three objectives identified for the past year. A sample of quarterly reports to the board of directors showed adequate information to monitor performance is reported including financial performance, risks, quality indicators and progress towards achieving the goals outlined in the business plan.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role for five years. She is also one of five shareholders in the ownership structure. Responsibilities and accountabilities are defined in a job description and an individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements. In the pandemic environment, she maintains close links with the DHB portfolio manager.</p> <p>The service holds a contract with DHB for dementia level care. Twenty-two permanent residents were receiving services under the contract at the time of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>A registered nurse based at the facility is delegated to provide relief and on-call in the occasional absence of the facility manager. She is experienced in the sector and takes responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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</p>	<p>FA</p>	<p>The organisation has a planned and embedded quality and risk system that reflects the principles of continuous quality improvement. This includes, management of incidents and complaints, internal audit monitoring activities, an annual patient satisfaction survey, monitoring of resident outcomes and clinical incidents, such as infections and falls. The organisation uses the 'Gibbs' cycle of improvement as its quality framework.</p> <p>Monthly general staff meetings and other quality related meetings (mostly held quarterly) are an effective means of communicating quality activities, improvements, and trends to staff. The agenda details topics</p>

<p>quality improvement principles.</p>		<p>including quality, project progress, care and assessment, complaints and feedback, health, safety and risk, maintenance, infection control and restraint as set agenda items. Meeting minutes reviewed confirmed regular review and analysis of all quality indicators. Staff interviewed reported their involvement in quality and risk management activities through audit activities and improvement projects, such as the falls reduction improvements. Relevant corrective actions are developed and implemented to address any shortfalls, with examples noted from audits, complaints, and resident/family feedback. Resident/family satisfaction surveys are completed annually. The most recent food survey showed a high level of satisfaction, including the home baking provided to residents.</p> <p>Policies reviewed cover all necessary aspects of the service including clinical care and contractual requirements. There is reference to the interRAI Long Term Care Facility (LTCF) assessment tool. Policies are provided through an external consultant. These are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and a system for the removal of obsolete documents.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies which are reviewed by the board. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. A health and safety committee meets quarterly, and new hazards are reported, discussed, and mitigated.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on a hard copy accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and followed-up to a conclusion in a timely manner. Adverse event data is collated, analysed, and reported at staff meetings and quality meetings and also to the board in summary form. No specific trends in incident types have been noted in recent months</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries and section 31 notifications. A sample were reviewed. She advised there have been no notifications of significant events made to the Ministry of Health, Worksafe, professional bodies or the coroner since the previous audit. There have been no employment court or police investigations undertaken.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance</p>	<p>FA</p>	<p>Human resources management policies and processes are based on current employment practices 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 across various staff groups confirmed the organisation's policies are being implemented and personnel records are consistently maintained. Staffing has been stable, although the vaccine mandate has required the recruitment</p>

<p>with good employment practice and meet the requirements of legislation.</p>		<p>of some new staff.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and a 'buddy' is available to support them during their initial employment shifts. Staff records reviewed showed documentation of completed orientation and an annual performance review which includes a self-assessment and goal setting for the coming year. Staff reported a positive culture of support and encouragement to learn the role, but also to get to know the residents and their individual needs.</p> <p>Continuing education is planned on an annual basis, including meeting mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB, including levels two, and three, with some staff commencing level four this year. Staff have also met requirements to complete the limited credit programme for the dementia specific training, with newer staff commencing this programme on completion of their orientation. Staff are encouraged to undertake level four NZ Qualifications Health and Wellbeing Certificate, with some staff now enrolled. Staff have also been encouraged to undertake the 'walking in another's shoes' programme to help develop skills when working with residents with dementia. Staff spoken to found this valuable in their approach to their day-to-day work. Although the full course has not been offered recently, due to Covid restrictions, the course convener has provided limited local sessions. Cultural safety was completed in 2021 and safe handling, spirituality and safe swallowing sessions are planned for 2022. Staff undertaking the food service have completed additional training via an online course titled 'Food Safety and Suitability' before commencing these duties.</p> <p>There is an interRAI trained and competent registered nurse, plus the facility manager (a currently practising physiotherapist) undertakes interRAI assessments. The two trained assessors maintain their annual competency requirements. Records reviewed demonstrated completion of the required training.</p> <p>Continuous improvement has been identified for the ongoing programme of improving staff culture and teamwork initiative (see 1.2.7.5).</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 is 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). The facility has flexibility to adjust staffing levels to meet the changing needs of residents through access to the internal casual staff pool shared across the two sites. Staff report that this works well, such as when a resident is very unwell or unsettled and extra support is required. Minimum staffing is overnight, with one staff member on duty and another on call caregiver living on site who is available and able to be called if required.</p> <p>The facility manager and registered nurse, share on call responsibilities after hours. Staff spoken to reported that good access to support and advice is readily available when needed. Care staff reported there were</p>

		adequate staff available to complete the work allocated to them, including where there are dedicated roles, such as cleaning and diversional therapy/activities. Residents and family interviewed supported that this works effectively. Inspection of the established weekly roster, the 'changes in shift' record sheet over four different weeks and the casual call roster, confirmed adequate staff cover has been provided, with staff replaced during any unplanned absence. This was noted to be covered during a recent close family bereavement for a staff member. All staff, including the activities coordinator, hold a current first aid certificate.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records are legible with the name and designation of the person stamped beside the entry. Archived records are held securely on site and are readily retrievable. They are held for the required period of time before being destroyed. No personal or private resident information was on display during the audit.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents are admitted to Southanjer following assessment from the Needs Assessment Service Coordination (NASC) service, as requiring the level of care that Southanjer provides. Prospective families and residents are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. All residents are admitted to the facility in accordance with current by Ministry COVID guidelines. Residents' files reviewed all have an activated enduring power of attorney (EPOA) in place and a specialist's authorisation for placement. Family/whanau members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a	FA	Exit, discharge, or transfer is managed in a planned and co-ordinated manner. The service uses the DHB 'Yellow Envelope' system to facilitate the transfer of residents to and from acute care settings. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing management

<p>planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The Medication Management Policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse signs in the medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are stored securely in accordance with 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 with controlled drugs signed in. There are currently no residents on controlled drugs.</p> <p>Good prescribing practices were noted. These included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. There are no standing orders or verbal orders. Vaccines are not stored on site. There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site with a qualified chef and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician and will be reviewed in April 2022.</p> <p>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 the Auditing Solutions (valid until 13th April 2022). At the time of the audit, the kitchen was observed to be clean. The cleaning schedule was maintained. Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using a paper base recording system.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to the chef and kitchen</p>

		<p>staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by families/whānau interviews. There is a selection of food available 24 hours a day with snacks, sandwiches and baking for residents. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received, but the resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the service due to inappropriate referral from the needs assessment service, there is a process in place to ensure that the prospective resident and family are supported to find an appropriate place of care. Examples of this occurring were discussed with the clinical manager.</p> <p>If the needs of the resident change and they are no longer suitable for the services offered, a referral for reassessment is made to the needs assessment service and in conjunction with the EPOA a new placement is found.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents at Southanjer are assessed using a range of nursing assessment tools, such as a pain scale, falls risk, skin integrity, cognition and behaviour, nutrition, and activities, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require.</p> <p>Interviews, documentation, and observation verified the RN is familiar with the requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site.</p>
<p>Standard 1.3.5: Planning</p>	FA	<p>Care plans at Southanjer are paper based. The files reviewed reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs</p>

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>identified by the interRAI assessments were reflected in the care plans reviewed. All files reviewed had a behaviour management plan in place and de-escalation strategies. Plans were updated as behaviour monitoring documentation determined a review may be required.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly documented, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Family/whanau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>CI</p>	<p>Documentation, observations and interviews with families/whanau verified that the care provided to the residents was consistent with their needs, goals, and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The GP interviewed confirmed that medical orders are carried out in a timely manner and staff are very proactive at contacting the GP should a resident's condition change, medical orders are followed, and residents care is of a high standard. A continuous improvement rating has been put forward for criterion 1.3.6.1 relating to a reduction in falls. Care staff confirmed that care was provided as outlined in the documentation and they have the opportunity for input into care planning.</p> <p>A range of equipment and resources were available and suited to the levels of care provided and in accordance with the resident's needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by one part time qualified diversional therapist who works in conjunction with two part time activities assistants. They support the residents Monday to Sunday 9.00am till 3.00pm.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. Each resident has a 24-hour activity plan that addresses the resident's needs and previous lifestyle patterns. The activities are evaluated and form part of a six-monthly multidisciplinary care plan review.</p> <p>It is the aim of the diversional therapist and activities assistants to get the residents engaging in the community as much as possible. They were the winners of the 2020 Aged Care Association "Winner Small</p>

		<p>Business Operator". The programme's focus was on residents' wellbeing and providing a sense of purpose. There is a "back yard" which has raised vegetable gardens, chickens, pigs and cattle all of which the residents are encouraged to become involved with, if they wish too. (Refer 1.4.2.4 – CI rating) There is a facility van available for drives in accordance with current COVID 19 restrictions.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, 'Housie', knitting and visiting entertainers as the COVID 19 restrictions allow. There are individual and group activities with one resident enjoying reading the newspaper to everyone. There are several lounge areas, as well as the individual's bedrooms where they can watch their own television or listen to the radio. The Activities Calendar is on display, and it emphasises and celebrates cultural beliefs on a regular basis.</p> <p>Families/whanau can evaluate the programme through day-to-day discussions with the activities co-ordinator and by completing the six-monthly resident satisfaction survey and the six monthly multi-disciplinary meeting. Families/Whanau interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI reassessment and the multidisciplinary team meeting, or as the residents' needs change. The RN documents evaluations. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain, weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability</p>	<p>FA</p>	<p>Families/whanau are supported to access or seek referral to other health and/or disability service providers on behalf of their relative. If the need for other non-urgent services are indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals were sighted in the residents' files. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.</p>

<p>service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. This includes a local contractor who removes general waste. There is kerbside recycling. Appropriate signage is displayed where necessary, including for the storage of gases on site.</p> <p>An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals were stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and ready availability of protective clothing and equipment stored on site, and staff were observed using this appropriately.</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>A current building warrant of fitness (expiry date 9 May 2022) was publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and well maintained. Extensive upgrades including rewiring throughout the facility and the installation of residual current devices (RCDs), and new flooring has markedly improved the environment for residents.</p> <p>Testing and tagging of electrical equipment and calibration of biomedical equipment was current as confirmed in the documentation reviewed and checks of electrical and biomedical equipment in use throughout the facility. The environment was hazard free and resident safety was promoted. Hot water temperatures at the tap are within the recommended range.</p> <p>External areas are safely maintained, accessible and were appropriate to the resident group and setting. Residents can access a spacious internal garden and paved seating area through various sliding doors to the outside. A continuous improvement rating has been awarded for the extensive work undertaken to improve the resident's outdoor environment (see 1.4.2.4).</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required, and these are actioned by the facility manager. Residents and family members were pleased with the improvements made to the environment.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities for resident use throughout the facility. No rooms have ensembles. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Shared bathrooms are in good repair with intact surfaces.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around safely within their bedrooms. All bedrooms provide single accommodation in spacious rooms with suitable space for mobility aids. Residents room were homely and personalised with furnishings, photos and other personal items displayed</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities and to relax. The dining and lounge areas are spacious and well used. The spaces are central to the facility and enable easy access for residents and staff and a focus for communal activities. Residents can also access areas for privacy, such as the conservatory if needing a quieter space. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic</p>	FA	<p>Laundry is undertaken on site in two separate laundry areas by care staff, and by family members if requested. The staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow, handling of soiled linen and drying processes. Survey feedback indicates that the laundry is managed well, and clothes are returned in a timely manner.</p>

<p>cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>Cleaning staff have received appropriate training and were very experienced. The colour coded cleaning system is fully understood and appropriately implemented. The internal environment is clean, and surfaces are in good repair. An external company provides a range of chemicals and training about the products. Chemicals are stored in a lockable cupboard or a closed system and were in appropriately labelled containers. Safety data sheets are available at the point of use.</p> <p>Cleaning and laundry activities are monitored through the internal audit programme and family feedback on the effectiveness of laundry processes.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>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 approval letter from the New Zealand Fire Service was sighted. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being in December 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including sufficient food, 400 litres of potable water, extra blankets, mobile phones, and a gas BBQ were sighted and meet The National Emergency Management Agency recommendations for the region. There is an agreement for a generator to be made available through a local provider if the need arises. Emergency lighting is regularly tested, and all other building owner responsibilities have been completed as required.</p> <p>A newly installed call bell system with a visual display alerts staff to residents requiring assistance. Staff were observed to respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Cupboards and staff only areas are kept secure with digital locks, and visitors are provided with a key code to enter and exit the main entrance. Doors and windows are locked at a predetermined time each evening.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and sliding doors that open to the outside courtyard and garden area. Electrical heating (ceiling panels) is provided in residents' rooms and in the hallways and communal areas. Areas were warm and well ventilated throughout the audit and families confirmed the facilities are maintained at a comfortable temperature.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Southanjer implements an infection prevention and control programme to minimise the risk of infection to residents, staff, and visitors. A comprehensive and current infection control manual is available to staff and managers. There is evidence that formal reviews of the programme are completed annually.</p> <p>The registered nurse is the designated infection prevention and control co-ordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and reviewed at the monthly meetings. Infection prevention and control matters are also discussed at staff handovers, staff meetings and ultimately at management meetings.</p> <p>Signage at the main entrance to the facility 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 and confirmed this had been further reinforced since the COVID-19 pandemic emerged.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN has the appropriate skills, knowledge, and qualifications for the role. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP and the public health unit, as required. The RN has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>There is a COVID-19 management plan in place which details all the actions required within the facility in response to each of the alert levels. The ICN and the manager confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documented in the front of each folder the latest review date. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are distributed around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by a suitably qualified RN and the DHB IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract, and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at staff meetings and during shift handovers. A good supply of personal protective equipment was available, and Southanjer has processes in place to manage the risks imposed by COVID-19.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Southanjer is a secure dementia unit, with all residents assessed as requiring this level of care. Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of restraints and enablers. The facility manager is the restraint coordinator and had a good understanding of the policy. Staff undertake annual training (most recently 2021) on the use of restraints and enablers.

		<p>Review of restraint processes is undertaken annually at the end of a quality meeting (last occurred March 2021). Any feedback needed is given at staff meetings.</p> <p>Policies state that restraint is used as a last resort when all alternatives have been explored but this has not been required. This was evident on review of the restraint approval group minutes, files reviewed, and from interviews with staff.</p> <p>There have been no restraints used at Southanjer and enablers have not been used for approximately three years. A similar process is followed for the use of enablers as is used for restraints.</p>
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Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	CI	<p>In 2017, there was evidence of poor teamwork and culture which had been identified through family satisfaction surveys and internal complaints by staff about other staff. A project to improve team culture commenced at Southanjer. This was subsequently awarded a continuous improvement rating at their 2018 certification.</p> <p>Since then, further work, investment and engagement in the programme has continued. The manager has further engaged an external consultant to support completion of staff personality profiling and promotion of teamwork. This incorporates both Southanjer and its sister facility. Attendance at the programme was compulsory. Staff feedback has been very positive as reflected in staff meeting minutes and active expressions of teamwork and reduced staff complaints.</p> <p>A further initiative has seen the introduction of a ‘book club’ forum at the monthly staff meetings, in which books outlining person-centred care, working as a team, and keeping up team morale have been discussed and debated as a group. A package of the three books is given to new staff at the commencement</p>	<p>Ongoing continuous improvement in relation to staff culture and teamwork since the audit in 2018 is evident and has been further developed. This is beyond the full attainment required by the standard. The initially successful quality improvement project has been continued and expanded to continually improve teamwork and staff culture aligned to the organisation’s goals to create a warm, homely environment for residents, whānau, and the wider team. The evaluation and reviews of the strategies introduced to date have shown a positive change in culture and improved resident outcomes</p>

		of their employment (namely Being Mortal by Atul Gawande, Ghost Boy by Martin Pretorius, and The Boy, the Mole, the Fox, and the Horse by Charlie Mosley). A new standing agenda item at staff meetings are the 'Blue Bus stories' using concepts that 'The Stories We Tell is the Culture We Create'. It focuses on positive stories from the team themselves. Feedback from staff has been very positive, as evidenced in meeting minutes, staff performance appraisal summaries reviewed and comments to/from families on the facility's private Facebook page.	evidenced through satisfaction surveys, staff appraisal summaries and in the nature and type of feedback/complaints/concerns raised.
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	CI	In early 2021, it was identified that there were several falls occurring. The registered nurse attended training on the 'Frailty Care Guides' and subsequently adjusted the incident reporting to be more in line with best practice and injury assessment. The manager a (registered physiotherapist) used the Frailty Care Guides to base a falls reduction project based on early identification of falls risk and falls prevention strategies (including assessment and identification of high-risk fallers, staff education, improved environment to be more conducive to falls reduction, medication reviews and exercises). Since the project was introduced, there has been a significant reduction in a) the number of residents identified as 'frequent fallers' and b) a reduction in the number of falls experienced by those residents identified as 'frequent fallers'. This was evidenced by documented reviews of the project.	Continuous improvement in relation to falls prevention was evident. A specific quality improvement project has been introduced to reduce the number of falls. The evaluation of the falls programme to date has shown a reduction in the number of residents experiencing falls and fewer falls by high-falls risk residents.
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	CI	In 2017 the residents of Southanjer had an accessible internal garden to enjoy (which is still available and well-maintained) but potential to utilise further spaces to better meet resident relaxation, activity (and dining needs) was identified. Over the past four years, extensive work has been undertaken to develop four large vegetable gardens, a chicken coop, a sty with pigs and shaded seating for the residents, whānau and team to enjoy the space. The area has been made fully accessible with a complete upgrade of the driveway and new paths. Residents access this area daily with staff or whānau, with a real sense of purpose to feed the chickens and pigs, collect eggs, harvest vegetables and herbs and enjoy local birdsong. This was evident when talking to residents, the team, families and in responses in resident/family surveys. The external area also has an extensive 'Memorial Tree Garden' where trees have been planted in memory of both Northanjer and Southanjer residents who have	Continuous improvement beyond the full attainment level required by the standard is recognised in relation to environmental improvements at Southanjer. A specific project to build 'Our Backyard', 'The Memorial Tree Garden' and driveway upgrade has significantly enhanced safety, suitable, age-appropriate, and accessible areas for the residents. The evaluation and reviews of this area include winning its category for the Aged Care Association/EBOS

		<p>passed away and plaques have been installed in their memory. This gesture has been appreciated by the families of residents who have passed away as evidenced by conversations with families, including a family member who has since become a dedicated volunteer. The value of this work in providing an area for residents, many of whom have rural and farming links, has been externally recognised with a national award. Development of both areas is continuing.</p>	<p>'Best Small Operator' Excellence in Care Award in 2020, from the 'before and after' photos of the huge changes to the environment, resident, team and whānau interviews and improved satisfaction survey results.</p>
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End of the report.