Windsor House Board of Governors - Windsorcare

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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Windsor House Board of Governors
Premises audited:	Windsorcare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 28 June 2021 End date: 29 June 2021

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: 72

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Windsorcare provides rest home, hospital, and dementia level care for up to 81 residents. At the time of the audit there were 72 residents in total.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management, and general practitioner.

There is a general manager (non-clinical) who has been in the role for six years and is responsible for operational management of the service. The general manager is supported by a clinical manager (registered nurse) and quality manager.

The service implements the organisations quality and risk management programme. An induction and in-service training programme that provides staff with appropriate knowledge and skills to deliver care and support is in place.

Residents and the general practitioner interviewed all spoke positively about the care and support provided.

This audit identified improvements required around completion of monitoring charts, care plan evaluations and progress note entries by a registered nurse.

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.

Windsorcare endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Staff demonstrated an understanding of residents' rights and obligations. Written information regarding consumers' rights is provided to residents and families. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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.

Windsorcare has a current strategic plan and a quality and risk management programme that outlines objectives/goals. The quality and risk management programme includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality information is reported to quality/management, staff, and clinical meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly meetings and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Windsorcare has job descriptions for all positions that include the role and

responsibilities of the position. There is an annual in-service training programme schedule in place. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Residents and family members report staffing levels are sufficient to meet resident needs.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

The registered nurses are responsible for each stage of service provision. The registered nurses assesses and plans, and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Electronic care plans viewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses, enrolled nurses, and caregivers responsible for administration of medicines complete education and medication competencies. The electronic medication charts reviewed met legislative prescribing and administration requirements and were reviewed at least three-monthly.

A diversional therapists and diversional assistants coordinate and implements the integrated activity programme for the residents, along with the caregivers. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and preferences for each consumer group. Residents and families report satisfaction with the activities programme.

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

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Resident bedrooms are personalised with own ensuites or shared ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is at least one staff member on duty at all times with a current first aid certificate.

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.

Windsorcare has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents with restraint and one using an enabler.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidence that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted-upon, evaluated and reported to relevant personnel in a timely manner.

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	42	0	3	0	0	0
Criteria	1	89	0	3	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Interviews with 14 care staff, including six caregivers, five registered nurses (RN), one enrolled nurse (EN) and two activities coordinators, reflected their understanding of the key principles of the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There are established informed consent policies/procedures and advanced directives. General consent is obtained for collection, storage, release, access and sharing of information, photograph for identification and consent for outings. Permissions granted are also included the admission agreements. There is documented evidence of discussion with the enduring power of attorney (EPOA) where the general practitioner has made a medically indicated not for resuscitation status. Copies of the residents' advance directive where applicable, are on file. Two files reviewed from the dementia unit had copies of the activated EPOA on file.
Standard 1.1.11: Advocacy And	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support services.
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 may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends, and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident/relative meetings are held every three months.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The general manager maintains a record of all complaints, both verbal and written, by using a complaint's register. Seven complaints made in 2020 and four complaints received in 2021 year to date evidenced appropriate action was taken. Documentation including acknowledgement letters, follow-up letters and resolution dates demonstrated that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed are followed up and implemented. One recent complaint made was being investigated and was still open.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at the entrance.to the facility. A manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the three-monthly resident/family meetings. Seven residents (five rest home and two hospital) and five relatives (one rest home, one hospital and three dementia care) interviewed reported that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with	FA	Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into

respect and receive services in a manner that has regard for their dignity, privacy, and independence.		the residents' care plans. Spiritual needs are identified, and church services are held. Staff have received training around abuse and neglect.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there were no residents that identified as Māori living at the facility. Māori consultation is available through local iwi links. There is a Kapa Haka Group that visits and performs at the facility.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the health and disability services standards. Policies and procedures are well established, cross referenced and reviewed regularly to ensure continuity of care. Staffing policies include the recruitment process, the requirement to attend orientation and participate in ongoing in-service education/training. Windsorcare has a current strategic plan and a quality and risk management programme that outlines objectives/goals. There is an annual in-service training programme schedule in place. There is an implemented quality and risk management programme that includes performance monitoring. There are implemented competencies for RNs, ENs and caregivers. There are clear ethical and professional standards and boundaries within job

		descriptions. Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed demonstrate a sound understanding of principles of aged care and state that they feel supported by the management team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Information is provided at entry to residents and family/whānau. Residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. Both the general manager and clinical manager are available to residents and relatives and they promote an open-door policy. Incident forms reviewed from April and May 2021 evidenced that relatives have been notified. Relatives interviewed advised that they are notified of incidents and when residents' health status changes promptly. Staff interviews described instances where relatives would be notified. Newsletters are available for relatives.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Windsorcare provides rest home, hospital (medical and geriatric) and dementia level care for up to 81 residents. On the day of the audit there were 72 residents in total, including 20 of 21 rest home residents (three of the rest home residents were located in the hospital wing), 32 of 40 hospital level residents, including two residents on end-of-life contracts. There were 20 of 20 dementia care residents. All permanent residents were on the age-related residential care (ARRC) contract. There are 10 dual-purpose beds in the rest home unit. At the time of the audit one rest home bed/room was being used as a whanau room. The service is governed by the Windsor House board of governors (there are eight board of governors including a chair). The board meets monthly and receives reports on all aspects of service delivery at Windsorcare. The general manager reports to the monthly board of trustees meeting. The service has a strategic plan in place for 2021-2024. The organisation has a philosophy of care which includes a mission statement. The general manager has a PhD in management and has been in the role for six years. He is supported by an experienced clinical manager, part time quality manager/RN (contracted), HR/payroll manager, administration/support person and long-standing staff. The clinical manager has been in the role for three years and provides clinical oversight at Windsorcare. She has 20 years' experience in aged care and clinical management. The general manager and clinical manager have completed in excess of eight hours of professional development in the past 12 months.

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	The clinical manager steps in when the general manager is absent. The clinical manager is supported by the quality manager, HR/payroll manager, administration/support person and the care staff.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Windsorcare has a strategic plan and a quality and risk management programme that outlines objectives/goals. Interviews with the general manager, clinical manager, quality manager and staff from each area reflect their understanding of the quality and risk management programme. Key components of the quality and risk management programme link to the monthly combined quality/management/infection control and health and safety meetings, and monthly clinical meetings. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure injuries and medication errors. The service has in place a range of policies and procedures to support service delivery that are reviewed regularly. Staff interviewed stated they are well informed and required to sign meetings minutes/reviewed policies when read. An annual internal audit schedule including specific clinical-focused audits was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in a variety of meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed. Quality improvements are raised for identified areas for improvement. There was a resident/relative satisfaction survey completed in February 2021. Corrective actions have been established around range of activities and food choice/quality in the rest home and hospital wings. There were no areas for improvement required in the dementia care wing. The health and safety committee meet monthly to review the accident/incident reports. The general manager is the health and safety officer and has completed health and safety training. Hazard identification forms are recorded for any hazards, accidents or near misses and there is a documented hazard register in place, last reviewed in November 2020. Staff undergo annual health and safety training which begins during their orientation. Falls prevention is discussed each month and there is a specific action plan in place for falls minimisation. Individual falls minimisation is documented in resident's care plans. Caregivers interviewed confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.

Standard 1.2.4: Adverse Event Reporting 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.	FA	Fifteen accident/incident forms (three rest home, eight hospital and four dementia care) were reviewed. All incident forms identified relatives' notification, timely RN assessment of the resident. Corrective actions to minimise resident risk were included in the resident care plans. Neurological observations had been completed as per protocol for six unwitnessed falls and any known head injury. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted. The general manager and clinical manager interviewed could describe situations that would require reporting to relevant authorities. There have been two section 31 notifications reported in 2020 including one non-facility acquired deep tissue pressure injury and one facility acquired unstageable pressure injury.
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	Eleven staff files were reviewed (the general manager, clinical manager, two RNs, four caregivers, two diversional therapists and one maintenance person). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. All staff must complete annual competencies prior to their appraisal. The register of nursing practising certificates and allied health professionals is current. The in-service education programme for 2020 has been completed and the 2021 programme is being implemented. A spreadsheet is maintained of all training for clinical and non-clinical staff. The attendance is monitored and recorded. Staff are reminded through the staff noticeboards and reminders using the time target system. Nine of ten RNs (including the clinical manager) have completed their interRAI training. Staff complete competencies relevant to their roles. Thirty-six of thirty-eight caregivers who work in the dementia care unit have completed the dementia unit standards. The two caregivers that have not completed have been enrolled to complete their dementia standards. There are 54 caregivers in total. Completed Careerforce training as follows; 35 have completed level four, seven have completed level three and 12 have completed level two training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled	FA	There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The electronic roster provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager and clinical manager both work full time from Monday to Friday. The general manager is available 24/7 for any operational or facility concerns, and the clinical manager is on call 24/7 for any clinical issues. Residents and relatives stated there were adequate staff on duty at

and/or experienced service providers.		all times. Staff interviewed felt that they are supported by the clinical manager who respond quickly to afterhours clinical concerns. Registered nurses have a roster pattern of four on – two off. Due to this, there are often more than two nurses on duty. In this case, one RN completes documentation. In the hospital North wing, there are 19 of 20 residents, 18 hospital residents (including two residents on the end-of-life contract) and one rest home resident. There is one RN on the morning and afternoon shifts and one on the night shift. The RNs are supported by four caregivers in the morning (two long and two short shifts), three caregivers in the afternoon (two long and one short shifts) and two caregivers on the night shift. In the hospital South wing, there are 16 of 20 residents, 14 hospital residents and two rest home residents. There is one RN on the morning and afternoon shifts. The RN in the North wing on the night shift covers the hospital South wing. The RNs are supported by four caregivers in the morning (two long and two short shifts), three caregivers in the afternoon (one long and two short shifts) and one caregiver on the night shift (one caregiver in the North wing floats between the wings). In the rest home wing, there are 17 of 20 rest home residents. There are three caregivers on the morning shift (two long and two short shifts), two caregivers on the afternoon shift (one long and one short shift) and one caregiver on the night shift. In the dementia care area, there are 20 of 20 dementia residents. An enrolled nurse (four on - two off) covers four hours of her shift in the dementia wing and four hours in the rest home wing. There are three caregivers (one medication competent) on the morning and afternoon shifts (two long and one short shift) and one caregiver on the night shift.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being held securely.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Residents are assessed prior to entry to the service by the needs assessment (NASC) team, and an initial assessment with an interRAI assessment completed on admission. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. There is specific information provided for families regarding dementia care.

manner, when their need for services has been identified.		In the dementia unit two resident files were sampled and had NASC approval for the service and EPOA activation letters on file. All admission agreements reviewed aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. A total of nine signed admission agreements were sighted. Family members interviewed confirmed the staff had fully explained services to them on entry to the service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.
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	There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, ENs and caregivers) have been assessed for competency on an annual basis. Registered nurses have completed syringe driver training. Annual education has been provided around safe medication administration. The service uses an electronic medication charting and administration record system. There is documented evidence of medication reconciliation on delivery of medications. All as required medications and impress stock is checked monthly for expiry dates. Medication fridges and medication storage rooms are checked weekly and are maintained within the acceptable temperature range. All eye drops and ointments were dated on opening. Standing orders are not used. Controlled drug medication is managed appropriately. There were no residents self-medicating on the day of audit. Medication charting is completed electronically by the GP. Eighteen medication charts (eight hospital, six rest home and four dementia) reviewed, had photo identification and allergy status recorded. All medication charts sighted were completed appropriately. A medication round was observed, and the RN completed the administration process correctly. All medications had been administered as prescribed. Medication errors are completed on the incident form and identified internal investigations, corrective actions (including repeated medication competencies) and discussion at clinical and management meetings.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food,	FA	All meals at Windsorcare are prepared and cooked on site. A kitchen manager is supported by a second cook and kitchen assistants. There is a four-weekly seasonal menu which had been reviewed by a dietitian in April 2021. The service has a food control plan verified and expired in April 2022. There are

fluids and nutritional needs are met where this service is a component of service delivery.		two menu choices for the midday and evening meal. Dietary requirements and pureed meals are provided. Resident dislikes are known and accommodated. Cultural and religious food preferences are met. Meals are plated in the kitchen onto heated plates and covered with insulated lids and delivered by trolley to the dining rooms. Staff were observed assisting residents with their meals and drinks in the hospital and dementia care dining rooms. The food presentation and end temperatures of the food served were satisfactory. There was specialised cutlery available, and staff were observed providing this to the residents. Noise in the dining rooms was reduced and sufficient number of staff were present during mealtimes. There were nutritional snacks available 24-hours in the dementia care unit. End cooked food temperatures, re-heating and serving temperatures are taken recorded on each meal. Fridge, freezer, and chiller temperatures are taken and recorded daily. Temperatures of inward goods are recorded. The dishwasher is checked regularly by the chemical supplier. All food services staff have completed training in food safety and hygiene and chemical safety. A kitchen cleaning schedule is in place and implemented. Dried goods and perishable foods are dated. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. The head cook attends the resident meetings. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.
Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	There is an admission information policy. The reasons for declining entry would be if the service were unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry is declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The clinical manager or an RN completes an initial assessment on admission including risk assessment tools. An interRAI assessment is undertaken within 21 days of admission and six monthly or earlier, due to health changes. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place for the resident files reviewed. The long-term care plans in place reflected the outcome of the assessments. There were no residents on respite care at the time of the audit.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident care plans reviewed were resident focused and individualised. All identified support needs as assessed were included in the care plans. Short-term care plans are used for wounds and any other short term or long-term changes to health status are added to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration. There was evidence of allied health care professionals involved in the care of the residents including physiotherapist, specialist dementia nurse, podiatrist, dietitian, occupational therapist, and gerontology nurse.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	When a resident's condition changes the RN initiates a GP or nurse specialist consultation. Short- term care plans are completed for changes to care/supports required and communicated at handovers. Registered nurses (RNs) and caregivers follow the care plan and report in progress notes against the care plan each shift. There is specialist input into the resident's care in the dementia unit as required. The community mental health/psychiatric nurses maintain a close liaison with the clinical manager/RN, GP and the psychogeriatrician based at the DHB. The relatives interviewed stated their expectations were being met and they were notified of any changes to health, incidents, infections, GP visits and medication changes. Staff reported there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. Sixteen wounds were recorded in the wound register (eight for the hospital one chronic wound), four for the rest home (including chronic wound) and four for the dementia unit, were managed at the time of audit. Wound assessments had been completed for all wounds. All wounds have wound assessments, pain scores, photos, sizes, dressing plan and evaluations. There was evidence of GP involvement and the wound nurse specialist had involvement in two chronic wounds. There were no pressure injuries being managed on the day of the audit. Appropriate pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury. Pressure relieving devices in place included roho cushion, comfort chairs, pressure relieving mattress, heel protectors and repositioning charts. Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such including poor mobility, falls, skin integrity, hypo and hyper glycaemia, swallowing difficulties and nutrition. Caregivers interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions. A range of monitoring forms are used including vital signs, neurological observations, weight, blood glucose levels, positioning, enabler monitoring, food and fluid intake, behaviour, and pain. However,

		forms related to challenging behaviour, repositioning charts, wound dressing, and pain monitoring were in place for the residents when required but were not completed within the stated timeframes/frequency. Behaviours that challenge have been well identified through the assessment process in the residents' files reviewed. Twenty-four-hour diversional care plans describe the resident's usual signs of wellness, changes and triggers, interventions, normal routine, and de-escalation techniques (including activities), for the management of challenging behaviours. Behaviour charts and behaviour monitoring were sighted in use for exacerbation of resident behaviours or new behaviours.
Standard 1.3.7: Planned Activities 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.	FA	The service employs two full time qualified diversional therapists (DT) who develop and implement the separate activity programme for the rest home, hospital, and dementia unit. They are supported by two activity coordinators. The programme identifies integrated activities that all residents are invited to attend in the entertainment room such as bowls, entertainment, exercises, movies and ice-cream, happy hour, housie, news reading, pet therapy, inter-home visits and competitions. There is a pamper room where residents can enjoy one on one activities with the activity staff. Combined activities are provided three times a week to include all resident groups. Community links are maintained and included a fundraising activity where the community was invited to have a stall on the day. There are a men's and ladies club that is well attended, this was established after residents' comments in the 2019 residents` that related to enhancing their interests. Each area also has activities that are meaningful and meet the resident preferences, physical and cognitive abilities of the resident group. There are also quiet spaces around the facility for residents and family to meet in private. A well-situated whānau room is available upstairs for meetings. Eight volunteers are involved in the activities and include piano players, one on one visiting and chats, board games and church services. One on one activities such as individual walks, massage, reading, arts, and crafts occur for residents who are unable or choose not to be involved in group activities. The dementia care programme is flexible around the residents needs and include sensory activities such as baking. The activity team complete a social profile on admission and a 24-hour plan for residents in the dementia unit. A description of the activities that meet the resident's needs in relation to individual, diversional, motivational, and recreational therapy during the 24-hour period is clearly documented. The recreation plan is part of the long-term care plan is updated six monthly or the same time as the interRAI assessments occur. The activity coordinators interviewed confirm they are involved in the MDT meetings of residents. There is a van available for weekly van outings. All drivers have a first aid certificate and completed a

		defensive driving course. Relatives and residents interviewed confirm they can provide feedback at the three-monthly resident meetings or with a resident/relative survey. Those interviewed are satisfied with the activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	The clinical manager, EN (with RN delegation) or RN evaluated all initial care plans (sampled) within three weeks of admission. Long-term care plans had been reviewed at least six monthly or earlier for any health changes for long-term residents. The multidisciplinary team meets at least six monthly or earlier for any health changes. Family is invited to attend the MDT review and are informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Evaluations documented if the resident goals had been met or unmet and changes made by the RN or EN (delegated and supervised) to reflect the resident's current needs/supports. Six of eight long term care files reviewed (one resident was recently admitted and did not yet required an evaluation) had ongoing evaluations and changes made to the long-term care plan if required. Two (of two) residents in the dementia unit had an evaluation completed three-monthly by the enrolled nurse but the long-term care plan did not evident the changes. The resident (as appropriate) and family are involved in the multidisciplinary review. The GP reviews the residents at least three monthly or earlier if required.
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 service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets and product are readily accessible for staff in the sluice rooms, laundry, and cleaning cupboards. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas. A chemical spills kit is available. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		day of audit.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 1 January 2022. A request list is completed for any maintenance and repairs and entered into a computer data base. An annual planned maintenance schedule is maintained and includes maintenance for internal and external areas, kitchen, laundry, and clinical areas. Annual testing and tagging of electrical equipment have been completed and calibrations of medical equipment. Essential contractors are available 24 hours. Hot water temperatures in resident areas are monitored and are maintained within acceptable limits. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access the outdoor areas. Seating and shade are provided. The rest home rooms are spacious with ensuites. An additional two rest homes rooms were assessed as suitable for dual purpose beds. There is sufficient space for cares to be delivered and for the transfer of residents by hoist if required. There are call bells at the head of the bed and in the ensuites. The dementia unit has an indoor/outdoor flow with pathways and entry/exits into two courtyards with gardens shade and seating. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
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	Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are a mix of rooms with ensuites and some with shared ensuites with privacy locks and shower curtains. Communal toilet facilities have a system that indicates if it is engaged or vacant. Residents interviewed confirmed care staff ensure their privacy is met when attending to hygiene cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed	FA	At present all rooms are used as single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms.

areas appropriate to the consumer group and setting.		
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	Communal areas within the facility include a lounge and dining room in each area along with additional smaller lounges/family rooms with tea/coffee making facilities in the rest home and hospital. There is a large, shared entertainment room where many integrated activities take place. Seating and space is arranged to allow both individual and group activities to occur. All furniture is safe and suitable for the residents. There are several seating alcoves within the facility. There is safe access to the communal areas and outdoors. The dementia unit residents have free access (weather permitting) to the safe outdoor environment. There is a family/whānau room upstairs for meetings.
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	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff seven days a week. The laundry has defined clean/dirty areas with an entry and exit door. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes. Equipment is serviced six-monthly. The cleaning trolley is kept in a locked cupboard when not in use. There is a chemical mixing dispenser located in the laundry. Adequate personal protective clothing was available for use. Residents and family interviewed reported satisfaction with the cleaning and laundry service.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency action plan in place to guide staff in managing emergencies and disasters. Fire training, emergency evacuation, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. There is a RN on site available to all residents 24/7. Fire evacuation drills take place every six months, with the last fire drill occurring on 27 April 2021. The NZ Fire Service approved the evacuation scheme on 11 August 2011. Smoke alarms, sprinkler system and exit signs are in place. A contracted service provides checking of all facility equipment including fire equipment. The service has alternative gas facilities (BBQ and gas hobs in the kitchen) for cooking in the event of a power failure. The service also has a generator on site for emergency lighting and battery backup. Civil defence and pandemic/outbreak supplies are available in and are checked six-monthly. There is food stored in the kitchen for up to three days. There is sufficient water stored (large water tank, ceiling tanks and bottled water) to ensure for three litres per day for three days per resident. There are call bells in all communal areas, toilets, bathrooms, and residents' rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility.

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	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The heating in each room can be individually controlled. There are sufficient doors and external opening windows for ventilation. All bedrooms have good sized external opening windows which are designed and installed to promote ventilation and to be secured as needed.
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 scope of the service.	FA	The infection control coordinator (acting clinical manager) oversees infection control for the facility and is responsible for the collation and reporting of infection events. Infection events are collated monthly for each of the areas (rest home, hospital, and dementia care) and reported to the quality and risk management meeting and infection control committee. Infection control is a standard agenda topic at facility meetings. Meeting minutes are available to all staff for reading. The 2020 infection control programme has been reviewed November 2020 and is linked to the quality system. Visitors are asked not to visit if unwell. Hand sanitizers are appropriately placed throughout the facility. Residents are offered the influenza vaccine and Covid vaccine.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has completed a half study day with Southern Community Laboratory in August 2020. The infection control coordinator and committee (RNs, enrolled nurses, general manager, caregivers, cleaning and housekeeping and administrator staff) have access to GPs, local Laboratory, the infection control nurse specialist, and public health departments at the local DHB for advice and an external infection control consultant specialist (Bug Control). The infection control coordinator receives updates and has access to relevant websites with up-to-date information.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative	FA	The service has an overarching infection control programme policy that links to Bug Control infection prevention and control policies, which are available at the service. These infection control policies and procedures are appropriate for the size and complexity of the service. The Bug Control infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. There is a site specific Covid-19 pandemic plan according to risk levels.

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	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred, provided by an external infection control specialist. The infection control coordinator has completed online infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records
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	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the quality and risk management and infection control committee meetings. Annual infection control reports are provided. Trends are identified, and preventative measures put in place. Internal audits for infection control including kitchen, cleaning and clinical care are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with caregivers and nursing staff confirm their understanding of restraints and enablers. There was one resident using enablers (bedrail and lap belt) on the day of audit. A register is maintained by the restraint coordinator/RN (clinical manager). On the day of the audit there were no residents with restraints in Windsorcare. Staff regularly receive education and training on restraint minimisation and management of challenging behaviour in the last 12 months.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	There are verbal and written handovers between shifts. The clinical manager and registered nurses working in the hospital could describe a process of clinical oversight, supervision and follow up process after adverse events in the rest home and dementia unit when care is provided by enrolled nurses and senior caregivers. Caregivers interviewed stated they are well informed of any changes in a resident’s health care status. In addition to handovers, when each shift ends there is a briefing meeting with the registered nurse who will sign a shift report. Adverse events are followed up by registered nurses (for example post falls and skin tears/wounds). There is always a registered nurse on duty. The clinical manager is on call for clinical issues that needs attention after-hours and on weekends. Progress notes are recorded daily by caregivers and are comprehensive; however, the registered nurse does not enter consistently in the progress notes for residents in the rest home and dementia unit. All files reviewed, evidence a registered nurse involvement in the initial care plans, interRAI assessment, long term care plans, short	There were inconsistent entries in progress notes by a registered nurse (gaps of 15 – 30 days) in two rest home and two dementia files reviewed.	Ensure progress notes include regular entries from a registered nurse to document regular resident contact/assessment. 60 days

		term care plans individual incident report forms and MDT meetings. Progress notes are maintained by caregivers and an enrolled nurse in the rest home and dementia unit. However, in four of the nine files reviewed there were inconsistent entries by a registered nurse (gaps of 15 – 30 days) in progress notes to evidence resident contact/assessment and oversight of care delivered by the enrolled nurse and caregivers. Interviews and supporting documentation provide evidence that this is a documentation issue.		
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.	PA Low	Nine of nine care plan documentation were completed with interventions and individualised goals to meet the needs of the resident. There is a range of monitoring forms implemented. Frequency of required monitoring is documented in the care plan. Staff interviewed confirm they are knowledgeable about the care monitoring required and monitoring forms are readily available for completion. One file reviewed of a resident recently admitted on end-of -life care had an initial assessment; the initial care plan documentation to manage comfort and pain. Neurological observations have been fully completed for three residents following unwitnessed falls. Weight, vital signs, food and fluid charts and enabler monitoring is completed as required. All of the current wound management documentation included a wound assessment, wound management plan, evaluation and short-term care plans (except the two chronic wounds) linked to the wound management plan. However, forms related to challenging behaviour, repositioning charts, wound dressing, and pain monitoring were in place for the residents when required but were not completed within the stated timeframes/frequency. Supplementary documentation evidence this is a documentation issue.	The following shortfalls were identified: i) Four wounds (two in the rest home and two in the hospital), the wound documentation/management was not completed within the stated dressing frequency. ii) Repositioning charts for one resident with high risk of skin breakdown in the hospital has not been completed within the stated frequency; this also included the infrequent monitoring of pain related to the chronic wound; and iii) Challenging behaviour recordings (one resident in the dementia unit) on the monitoring chart does not correspond with the frequency documented in	Ensure monitoring forms are completed within the required stated timeframes 90 days

			the progress notes.	
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Low	Evaluations for care plans in three rest home, three hospital and two dementia unit resident`s files were reviewed. This occurred within the required timeframes and evidence the resident progress towards an individual measured goal. All but two files (dementia unit) evidence changes different from the expected outcome is documented in the care plan with updated goals and interventions. Evaluations to the care plan for residents in the dementia unit (two of two) files are documented by an enrolled nurse but changes do not reflect in the care plan.	Evaluations of two (of two) residents in the dementia unit reflect interventions including allied health instructions such as a diet change, outpatient appointments. Interventions were not updated in the care plan.	Ensure evaluations different from expected outcomes are documented in the care plan by making the necessary changes to the goals and interventions. 60 days

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
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	The activities team has embedded a resident focussed activity programme that is meaningful, aged appropriate, varied, and inclusive of all residents across the service. Following residents and relatives feedback the activities team initiated various activities in collaboration with residents, family and whānau. Residents’ satisfaction with the activities is evidence in the positive feedback in the 2020 and 2021 resident/relative surveys. Satisfaction and feedback are measured in various ways include collecting written feedback from residents through short surveys related to activities (March 2020 to May 2021), active feedback from relatives (documented as compliments or in meeting minutes [sighted]) and resident attendance numbers. Residents are part of the decision	The following activities were initiated to improve wellbeing, create a sense of belonging, maintain connections with the community and create events that they would normally not be able to access: 1.Creating a Men’s and Ladies club in October 2019. These activities include regular outings as a group (men and ladies separate) and residents choose the venue and type of activity for the day. Activities stimulate friendship and interest. The positive feedback collated in March 2020 and April 2021 from the residents were evident how much this activity is appreciated. The interest in both groups have increased in attendance numbers and are currently between twenty-one and twenty-three attendees at outings or events. Residents confirmed in their feedback forms how they missed being part of the group during the Covid-19 risk period. 2.A` pamper room` was created in the North wing in June 2019 to simulate a massage/salon/relaxation area. The area creates a

		making and this is evident in meeting minutes and short feedback surveys. The following documentation was reviewed: annual satisfaction surveys, feedback collated through short surveys, participation registers, photos and continuous improvement documentation folder, meeting minutes and individual resident files (where applicable). Staff and residents interviewed confirm the overall wellbeing of residents improved.	space for one-on-one activities or smaller group activities. The target group was initially hospital residents that may missed out on weekly van outings, however the popularity increased and is evidence in the attendance numbers in the participation registers. Feedback was collated in March 2020 and May 2021 include ` I like to have different colours on my nails each week`; for me it meets my expectations, especially the hand massages` and ` I love to go there every week`. The general manager confirmed that the project had been a great success. 3. Doll therapy was introduced in June 2019 as recognised therapy for several residents in the dementia unit after assessment for suitability and consultation with relatives/ whānau. The goal is to improve comfort, engagement and decrease behaviours related to agitation and anxiety. The activity team confirm this is part of the 24-hour activity plan, interventions, and de-escalating techniques in the care plan. Behaviour charts were reviewed to evidence the successful and positive outcome for individual residents after introducing the therapy. Staff interviewed also confirmed positive resident outcomes. 4. Regular family support meetings were created for family/whānau with relatives in the dementia unit. These meetings are well attended (12-15 attendees) mostly by the residents' children. The meeting is held after hours to ensure relatives can attend after work. The goal of the meeting is to share fears, meet other family members, share ideas and learning experiences related to dementia. These meetings are documented, and feedback is collated to improve the service but also to celebrate successes. Several written compliments were reviewed and include appreciation letters form family.

End of the report.