

# Glenhays Limited - Northanjer

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## 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:** Northanjer

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 February 2022      End date: 24 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:** 13

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	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

Northanjer provides rest home care for up to fifteen residents. The service is operated by Glenhays Ltd and managed by a facility manager who is also a shareholder. This service is operated in conjunction with a sister facility offering dementia care elsewhere in Oamaru (Southanger).

This certification audit was conducted against the Health and Disability Services Standards (2008) and the service's contract with the DHB and the MoH and carried out during the restrictions of the red traffic light system. Due to the impact of the pandemic, a spot audit was deferred in 2020. The audit processes included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a general practitioner. The manager oversees both services. Residents and families spoke positively about the care provided.

This audit has resulted in two continuous improvement rating in relation to staff culture and community connections. No areas requiring improvement were identified.

## 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 Northanjer 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 Northanjer 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.

Northanjer 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 established quality and risk management system includes collection and analysis of quality improvement and trending data. Opportunities to improve systems and processes and the quality of life of residents is planned and implemented through improvement projects. Adverse events are documented with corrective actions implemented from audits, events or where improvement is needed. Staff are fully involved with residents and families, with feedback 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 current individual performance review. Staffing levels and skill mix meet the changing needs of residents. There is a small casual pool of staff who also provide some cover for the sister service.

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.		Standards applicable to this service fully attained.
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Resident admission 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 and their family 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 in the rest home and hospital.

The planned activity programme is delivered by one part time activities assistant and overseen by the diversional therapist. The programme provides a variety of individual and group activities and maintains 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 food available for residents 24 hours a day. Policies' guide the food service delivery supported by staff 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 equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

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

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

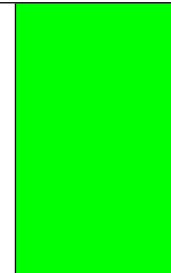
## Restraint minimisation and safe practice

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. Use of enablers is voluntary for the safety of residents in response to individual requests if required. Staff have received training and demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	2	91	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Norhanjer 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. Residents receive 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 give informed consent.</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>Staff were observed gaining consent for day-to-day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents 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 and residents spoken to 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.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family 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 dealings with the staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to raise a concern/complaint. The completed complaint form is given to the EN or manager, who considers the complaint and instigates any immediate action necessary. As part of the complaint process, acknowledgement is sent to the 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>	FA	<p>When interviewed, the residents and family/whānau of Northanjer 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 and there are eight rooms with private ensuite facilities, several communal lounges and a shared dining area. There are several lounges located throughout 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 outside in the community 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 that identified 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 in the facility and can act as a resource.</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</p>	<p>FA</p>	<p>Residents verified that they were consulted on their 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 of daily living. Residents' survey results evidenced that the residents' needs are being met.</p>

respect their ethnic, cultural, spiritual values, and beliefs.		Staff can access an external interpreter service for residents if required and several staff members are bi-lingual.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. One of the facility nurse practitioners 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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service provides and encourages good practice, this is demonstrated through evidence-based policies, input from external specialist services and allied health professionals, for example district nurses, dieticians, podiatrist, 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.  Staff reported that they receive management support for external education and access their own professional networks.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their own or their relative's status, they are 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 that were reviewed. There was also evidence of resident/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.
Standard 1.2.1: Governance The governing body of the organisation ensures services are	FA	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

<p>planned, coordinated, and appropriate to the needs of consumers.</p>		<p>documents described annual and longer-term objectives and the associated operational plans, with three 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 contracts with DHB for respite and rest home level care. Thirteen permanent residents were receiving services under the contract at the time of audit.</p>
<p><b>Standard 1.2.2: Service Management</b></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>When the facility manager is absent, the registered or enrolled nurse carries out all the required duties under delegated authority. During absences of the enrolled nurse, the clinical management is overseen by the registered nurse based at the sister facility. She is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned and embedded quality and risk system that reflects the principles of continuous quality improvement. This includes, for example, management of incidents and complaints, audit monitoring activities, a regular patient satisfaction survey, monitoring of resident outcomes, clinical incidents including infections and falls. The organisation uses the 'Gibbs' cycle of improvement as its 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 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</p>

		<p>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. The enrolled nurse is planning to undertake health and safety training.</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>	FA	<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. Appropriate follow up had occurred in relation to a cluster of medication events, including staff training.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries and section 31 notifications. 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 with good employment practice and meet the requirements of legislation.</p>	FA	<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 consistently implemented and records are consistently maintained. Staffing has been stable, although the vaccine mandate has had a recent impact.</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. Staff records reviewed showed documentation of completed orientation and</p>

		<p>an annual performance review which includes a self-assessment and goal setting for the coming year. Staff undertaking food service have completed additional training via an online course titled Food Safety and Suitability before commencing these duties.</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. A staff member is the internal assessor for this programme. 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. 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.</p> <p>There is an interRAI trained and competent registered nurse, plus the facility manager (a currently practising physiotherapist). An enrolled nurse is presently training as an interRAI assessor. 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 and extra support is required. Minimum staffing is overnight, with one staff member on duty and another on- call caregiver available (living on site) and able to be called on if required.</p> <p>The facility manager, registered nurse, and Northanjer enrolled nurse share on call responsibilities afterhours. Staff spoken to reported that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them, including where there are combined roles such as caregiving with cleaning or cooking responsibilities. 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.</p>



<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>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.</p> <p>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.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents are admitted to Northanjer following assessment from the Needs Assessment Service Coordination (NASC) service, as requiring the level of care that Northanjer provides. Prospective residents and their families 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.</p> <p>Family 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.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>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, are provided for ongoing management 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 enrolled 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.</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.</p> <p>There is a documented process for any residents who are self-medicating. This is decided in conjunction with the GP, EN and the resident. Self-medication documentation is completed by the GP and a copy is placed in the notes. At the time of the audit there was one resident self-administering medication in the facility.</p> <p>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 cook 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 in November 2021.</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 Ministry of Primary Industries (valid until 17th 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 kitchen 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 resident and families/whānau interviews, satisfaction surveys and in residents' meeting minutes. There are a selection of snacks and sandwiches for residents available 24 hours a day. 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><b>Standard 1.3.2: Declining Referral/Entry To Services</b></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>	<p>FA</p>	<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 NASC, there is a process in place to ensure that the prospective resident and family are supported to find an appropriate level 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 NASC and a new placement is found in consultation with the resident and the whanau/family.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents at Northanjer 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 and EN are familiar with 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> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans at Northanjer 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 identified by the interRAI assessments were reflected in the care plans reviewed.</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. Residents and 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>FA</p>	<p>Documentation, observations and interviews with residents and families 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. 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 such as pressure relieving devices.</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 activities assistant overseen by a qualified diversional therapist. They support the rest home residents Monday, Wednesday and Friday 1.00pm till 6.00pm. Activities and movies are available for the residents at the weekends with the support of the carers.</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. The activities are evaluated and form part of a six-monthly multidisciplinary care plan review.</p> <p>It is the aim of the activities assistant and diversional therapist to get the residents engaging in the community as much as possible as was evident with the fundraising project already referred to. There</p>

		<p>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, regular church services, 'Housie', knitting and visiting entertainers prior to the COVID-19 restrictions. There are individual and group activities for female and male residents. There are several lounge areas, as well as the individual's bedrooms where they have the opportunity to watch their own television or listen to the radio. The Activities Calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.</p> <p>Residents and families 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. Residents interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the EN who discusses with the RN overseeing the facility. 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. Evaluations are documented by the EN and signed off by the RN overseeing the care of the residents. 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. Residents and 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)</p> <p>Consumer support for access or referral to other health and/or disability service providers is</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. 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>

appropriately facilitated, or provided to meet consumer choice/needs.		
<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>	FA	<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 council kerbside recycling.</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, 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>	FA	<p>A current building warrant of fitness (expiry date 24 July 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/s and setting. A new deck, with suitable seating and shade has been installed and is readily accessible for residents.</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>
Standard 1.4.3: Toilet, Shower, And Bathing Facilities	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes seven rooms with ensuites. Appropriately secured and approved handrails are provided in

<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>		<p>the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Shared and personal 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>	<p>FA</p>	<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. Rooms are personalised with furnishings, photos and other personal items displayed. Residents spoken to expressed satisfaction with their personal space.</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>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities and to relax. The dining and lounge areas are spacious and enable easy access for residents and staff and a focus for communal activities. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. A free-standing wood fire has been installed in the lounge, with residents reporting how much they enjoy the warmth and cosy atmosphere it provides.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken on site by care staff, and by family members if requested. Care staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow, handling of soiled linen and drying processes. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>Caregivers share the cleaning tasks and have received appropriate training. Those spoken to understood the colour coded cleaning system. Staff are trained in the correct cleaning processes from orientation onwards and are initially buddied with a more experienced worker until they feel confident. 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>

		Cleaning and laundry activities are monitored through the internal audit programme and resident satisfaction on the effectiveness of laundry processes is sought through the regular resident survey.
<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>	FA	<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 was approved by the New Zealand Fire Service on the 2 November 2001. 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 food, stored potable water, extra blankets, mobile phones, and a gas BBQ were sighted and meet The National Emergency Management Agency recommendations for the region. Water storage tanks are within the building complex, and there are arrangements for a generator to be made available through a local provider. Emergency lighting is regularly tested, and all other building owner responsibilities have been completed as required.</p> <p>Call bells using a pager system alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. 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 comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and sliding doors that open onto outside the new deck 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 residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection</p>	FA	<p>Northanjer 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, in conjunction</p>



<p>to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>with the enrolled nurse. The role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and reviewed at the monthly quality committee meetings. Infection prevention and control matters are also discussed at staff meetings, handovers 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 with a documented process for each of the alert levels.</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>	<p>FA</p>	<p>The IPC coordinator 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 IPC coordinator 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 IPC coordinator and the quality 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 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</p>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documented on each policy the next 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>

service provided.		
<p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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 suitably qualified RNs and the 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.</p>
<p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>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.</p> <p>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 Northanjer has processes in place to manage the risks imposed by COVID-19.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>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> <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 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 Northanjer and enablers have not been used for approximately four 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

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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
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## Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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 1.1.12.2 Consumers are supported to access services within the community when appropriate.	CI	In 2021, it was identified that there was an opportunity to increase the resident’s links with the community through fundraising after a resident suggested the same after a monthly resident’s activity meeting. The residents worked together throughout the year and collectively (through creating and selling a recipe book of family favourites of the residents and team, selling their different creations at a stall at the local farmers market, and hosting a fundraising BBQ at their home) raised \$5000 for the ‘I am Hope’ charity. It was evidenced through activities and team meeting minutes, satisfaction surveys and resident and whanau interviews that the sense of purpose and enjoyment that the residents had out of fundraising for others was paramount and they are planning on fundraising for different charities annually.	Continuous improvement in relation to building community connections was evident in the lives of the residents of Northanjer. A specific project aiming to empower them to fundraise for charity has given the residents a sense of purpose and satisfaction in supporting others in need as evidenced by meeting minutes, satisfaction surveys and resident interviews as part of the evaluation of this project.

<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>	<p>CI</p>	<p>In 2017, there was evidence of poor teamwork and culture which was identified through family satisfaction surveys and internal complaints by staff about other staff. A successful project to improve team culture commenced at the sister facility resulting in a continuous improvement rating awarded at their certification audit in 2018. This included for engagement of an external consultant to support staff training and ongoing work to improve the organisational culture.</p> <p>Since then, further work, investment and engagement in the programme has continued and has now been expanded and introduced at Northanjer. The manager has engaged an external consultant to support completion of staff personality profiling and promotion of teamwork across the organisation. 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 as a group. A package of the three books is given to new staff at the commencement 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, performance appraisal summaries reviewed, and comments to/from families on the facility private Facebook page.</p>	<p>Ongoing continuous improvement in relation to staff culture and teamwork is beyond the full attainment required by the standard. The initially successful quality improvement project at the sister facility has been expanded to now include Northanjer. The focus has been to continually improve teamwork and staff culture closely 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 and wellbeing through high levels of satisfaction in the resident surveys, staff appraisal summaries and in the nature and type of feedback/complaints/concerns raised.</p>
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End of the report.