

Glenbrae Resthome and Hospital Limited - Glenbrae Resthome and Hospital

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 Health and Disability Auditing New Zealand 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:	Glenbrae Resthome and Hospital Limited
Premises audited:	Glenbrae Resthome and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 March 2016 End date: 8 March 2016
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:	31

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

Glenbrae Rest Home is owned and operated by the Arvida group. The service provides care for up to 57 residents requiring hospital/medical and rest home level care. On the day of the audit, there were 31 residents. The service is overseen by a facility manager, who is a registered nurse and well qualified and experienced for the role and is supported by the area manager. Residents and the GP interviewed spoke positively about the service provided.

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, staff and management. This audit has identified the following areas requiring improvement; hazard register, informed consent, service provision, care planning and medication management.

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.		Some standards applicable to this service partially attained and of low risk.
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Staff at Glenbrae Rest Home strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. Incidents and accidents are reported and followed through. A comprehensive education and training programme has been implemented with

a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Entry to the service is managed primarily by the village manager and clinical manager. There is comprehensive service information available. Initial assessments are completed by the registered nurses. Care plans and evaluations are completed by the registered nurses. Care plans are based on the interRAI outcomes and other assessments. There is evidence of other allied health professional input into resident care. Residents and family interviewed confirmed they were involved in the care planning and review process.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff has had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners reviewed residents at least three monthly or more frequently if needed.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are sufficient lounges and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and laundry staff are providing appropriate services. Staff have planned and implemented strategies for emergency management.

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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Glenbrae Rest Home 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 two residents with restraint and no residents with an enabler. Restraint management processes are adhered to.

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. The programme provides information and resources to inform the service providers. Documentation evidences 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	45	0	4	1	0	0
Criteria	0	96	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (seven healthcare assistants, two registered nurses (RN), one clinical nurse leader CNL), one diversional therapist, one physiotherapist and one facility manager) confirm their familiarity with the Code. Interviews with five residents (four rest home and one hospital) and four families (two rest home and two hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident, staff and quality meetings.</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>	PA Low	<p>Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement and additional consents are signed by the resident or their EPOA. The admission agreements are signed on admission. Advanced directives are signed for separately. The caregivers and the registered nurse interviewed confirmed verbal consent is obtained when delivering care. Discussion with family members identified that the service actively involves them in decisions that affect their relative's lives. There was evidence of EPOA's for residents that are deemed not competent signing</p>

		not for resuscitation forms on their relative's behalf.
<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>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interviews with staff and residents informed they are aware of advocacy and how to access an advocate.</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 encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</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 service has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register. Verbal and written complaints are documented. There were three complaints in the past twelve months and all complaint documentation was reviewed. All complaints had noted investigation, timeframes, corrective actions when required and where required, resolutions were in place. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the facility manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of</p>

		the Code.
<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>	FA	<p>The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.</p> <p>There is a policy that describes spiritual care. Church services are conducted regularly. All residents interviewed indicated that resident's spiritual needs are being met when required.</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>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. Four residents identified as Māori on the day of the audit and cultural needs were addressed in care plans sampled.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and reviewed as demonstrated in resident files sampled. Discussions with staff confirm that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including resident's cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p> <p>Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident. This ensures full and frank open disclosure occurs. Eight incidents/accidents forms were reviewed. The forms included a section to record family notification. All eight forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Glenbrae Home and Hospital is owned and operated by the Arvida group. The service provides rest home and hospital – geriatric/medical level care for up to 57 residents. This includes 16 serviced apartments certified to be able to provide rest home level care and 41 dual purpose beds. On the day of the audit, there were 15 rest home level and 16 hospital level residents. This includes one hospital resident receiving palliative care and one hospital resident admitted on the long term chronic care contract. There were no residents receiving care in the serviced apartments.</p> <p>The facility manager is a registered nurse and maintains an annual practicing certificate. She has been in a management role at the facility for 4 years. The facility manager is supported by a clinical manager (RN) and a clinical nurse leader (RN). The facility manager reports to the area manager weekly on a variety of operational issues. Arvida has an overall</p>

		business/strategic plan and Glenbrae has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. Glenbrae is currently transitioning to the Arvida group quality management systems and Arvida policies and procedures. The facility manager has completed in excess of eight hours of professional development in the past twelve months.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	In the absence of the facility manager, the clinical manager is in charge with support from the area manager, the clinical nurse leader, the senior registered nurse and the care staff.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>There is a business/strategic plan that includes quality goals and risk management plans for Glenbrae Home and Hospital. Interviews with staff confirmed that quality data is discussed at monthly staff meetings to which all staff are invited. The facility manager advised that she is responsible for providing oversight of the quality programme on site, which is also monitored at the organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. The site specific service's policies are being transitioned over to the Arvida Group policies which will be reviewed at least every 2 years across the group. New/updated policies are sent from head office. Glenbrae has implemented the Arvida Group interRAI assessment policy. Staff has access to manuals. Resident/relative meetings are held regularly. Restraint and enabler use is reported within the quality and clinical staff meetings.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system, however not all aspect of this system have been regularly reviewed. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The 2015 survey indicated a high level of satisfaction.</p>
Standard 1.2.4: Adverse Event Reporting	FA	There is an accidents and incidents reporting policy. The facility

<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly quality meetings including actions to minimise recurrence. A registered nurse conducts clinical follow up of residents. Eight incident forms sampled (from a sample of resident files) demonstrated that appropriate clinical follow up and investigation occurred following incidents. Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>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.</p>	<p>FA</p>	<p>There are human resources management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files were reviewed (one facility manager, one clinical manager, one enrolled nurse, one healthcare assistant, one diversional therapist, one maintenance, one cook and one cleaner) and evidence that reference checks were completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2015 has been completed and a plan for 2016 is being implemented. The facility manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Three of the six registered nurses have completed interRAI training. Annual staff appraisals were evident in all staff files reviewed.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Glenbrae Home and Hospital policy includes staff rationale and skill mix. Sufficient staff is rostered on to manage the care requirements of the residents. In addition to the facility manager (a registered nurse), who works full time, there is at least one registered nurse on at any one time. The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately</p>	<p>FA</p>	<p>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</p>

recorded, current, confidential, and accessible when required.		protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse.
<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>	FA	The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The village manager and clinical manager screen all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the village manager. The admission agreement form in use aligns with the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.
<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>	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.
<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>	PA Moderate	Twelve medication charts were reviewed (four rest home (including one respite) and eight hospital (including one long term chronic health condition). The registered nurse and healthcare assistants' complete annual medication competencies and medication education. The registered nurse was able to describe her role in regard to medicine administration. The registered nurse was observed administering medications safely. Staff sign for the administration of medications on medication sheets held with the medicines. Shortfalls were identified around medication documentation and management.

		<p>There were four self-medicating residents at the time of the audit and all had a current competency assessment. All self-medicating residents were monitored each shift as to whether they had taken their medication or not. Medications were securely and appropriately stored. The facility does not use standing orders. The medication fridge temperatures are recorded daily and were within the acceptable range.</p> <p>Medication profiles reviewed were legible and charts evidenced photographs and allergies documented. All medication charts reviewed evidenced that the GP has reviewed the resident's medication three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the cook works closely with the RN and care staff. The kitchen staff have completed food safety training. The cook follows a rotating seasonal menu which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored daily and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family/whānau members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a resident's health condition in files sampled. Care plans reviewed were developed on the basis of these assessments for files sampled (link 1.3.5.2).</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>PA Low</p>	<p>The RN's are responsible for all aspects of care planning. The care plans reviewed demonstrated service integration and input from allied health. Not all care plans included specific interventions for all identified care needs. Care plans were not always documented to reflect acute changes in health status. Family/whānau members interviewed confirmed the care delivery and support by staff is consistent with their expectations.</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>The registered nurse and healthcare assistants follow the care plan and report progress against the plan at least daily or more frequently if needed. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff has access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Ten wounds were reviewed. There were three wounds in the hospital (one ulcer and two skin tears) and seven wounds in the rest home (all skin tears). Each wound had a wound assessment completed, monitoring and wound management plans in place. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service and this could be described at interview.</p> <p>Interviews with registered nurses and healthcare assistants demonstrated an understanding of the individualised needs of residents. Food and fluid charts are completed as required.</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>Two diversional therapists are employed part time to coordinate the five day activities programme for all residents. They are assisted by a part time activities coordinator and a volunteer. The volunteer comes in on a Saturday morning to play housie. Each resident has an individual activities assessment on admission and from this information, an individual activities plan is developed. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. There is a high level of community involvement which includes a local early childhood centre which the residents visit fortnightly and take part in activities with the</p>

		children. The facility has its own van for weekly outings. There is a men's group and a women's group with appropriate speakers and activities for each group. All long term resident files sampled have a recent activities plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans were evaluated by the registered nurse within three weeks of admission in files sampled. The long-term care plans were evaluated at least six monthly or earlier if there is a change in health status in files sampled. There was at least a three monthly review by the GP in these files. Not all changes in health status were documented and followed up (link 1.3.5.2). Care plan reviews are signed by the RN in files sampled. Short-term care plans were evaluated and resolved or added to the long-term care plan if the problem is ongoing in resident files sampled. Where progress is different from expected, the service doesn't consistently respond by initiating changes to the care plan (link 1.3.5.2)
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	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurse initiates referrals to nurse specialists and allied health services. Other specialist referrals were made by the GP. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical	FA	The building has a current building warrant of fitness which expires in February 2017. The building has a number of lounge areas. The part

environment and facilities that are fit for their purpose.		time maintenance person is managing the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. Since the previous audit, improvements have been carried out so that all bedrooms now have either their own ensuite including a shower or a shared ensuite with the neighbouring room. Improvements have also been made to the outdoor areas with the addition of seating and gardens.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All bedrooms have ensuites. Toilets have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. All bedrooms are single rooms. Residents are encouraged to personalise their bedrooms.
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	The communal areas include a large lounge area and four small sitting areas around the facility. There are two dining areas, one specifically for those residents who need assistant with eating. The communal areas are easily and safely accessible for residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The facility is cleaned by dedicated cleaning staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents and relatives interviewed were satisfied with the

		<p>standard of cleanliness in the facility.</p> <p>All laundry is done on site by dedicated laundry staff who are assisted by the healthcare assistants with the putting away of laundry. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</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>General living areas and resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Glenbrae Home and Hospital has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from all staff and other members of the quality management team (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection</p>

		control programme has been reviewed annually.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team have good external support from the Arvida Group head office and the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available</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 service provided.</p>	FA	<p>There are site specific Glenbrae Home and Hospital infection control policies and procedures appropriate to for the size and complexity of the service. The 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. The policies are being transitioned over to the Arvida Group Infection Control Policies.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>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. The infection control coordinator attends the Arvida Group infection control training and is provided with education and updates through this forum. 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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Glenbrae Home and Hospital infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager and area manager. There</p>

		<p>have been no outbreaks since the last audit.</p> <p>Surveillance of all infections is entered on to a monthly resident infection data sheet and then analysed and evaluated and reported to staff meetings.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were two residents with restraint (bedrails) and no residents with an enabler. Both restraint files were sampled. All necessary documentation has been completed in relation to the restraints. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality meetings. A registered nurse is the designated restraint coordinator.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. The assessments reviewed for use of restraint were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau. The restraint coordinator, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed had a</p>

		<p>completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enablers register which is updated each month.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly quality and health and safety meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.7</p> <p>Advance directives that are made available to service providers are acted on where valid.</p>	PA Low	<p>Four of five files reviewed were of residents who were deemed competent. All four of these files had advanced directives in place. The facility had a system of red dots on files of those residents who wished to be resuscitated. The ‘do not resuscitate’ form in use for those residents deemed not competent does not meet current legislation. Since the draft report, the service has updated their policy and procedure to meet current legislation.</p>	<p>The ‘do not resuscitate’ form in use for those residents deemed not competent does not meet current legislation</p>	<p>Ensure that EPOA’s and next of kin do not make a do not resuscitate decision on behalf of their relative</p> <p>90 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate</p>	PA Low	<p>There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. Staff are reporting</p>	<p>The site specific centralised hazard register has not been updated or reviewed since 2010.</p>	<p>Ensure regular review of the hazard register.</p>

<p>communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>hazards and the hazards are being managed and discussed at site meetings. There is no evidence of regular review or update of the site specific centralised hazard register.</p>		<p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Nine of twelve medication charts sampled evidenced that medication was given as prescribed.</p>	<p>(1) Three of twelve medication charts sampled had gaps on the signing sheet; (i) one hospital resident prescribed Vitamin B 12 monthly was not signed as administered in December, (ii) one hospital resident prescribed three monthly Zoladex was last signed for as administered in September 2015.</p> <p>(2) One hospital resident was on continuous oxygen that was not prescribed by the GP,</p> <p>(3) One rest home resident was prescribed both regular and “as required” morphine (PRN). (i) The administration of the regular and PRN morphine was recorded on one signing sheet and there was no review of how much morphine</p>	<p>(1) Ensure all medication is given as prescribed. (2) Ensure that oxygen is prescribed; (3) Ensure that PRN medication is signed for on a separate signing sheet to the regular medication and that there is a regular review of PRN medication administered. Ensure that all medication is administered at the time prescribed.</p> <p>30 days</p>

			was received in a 24 hour period. (ii) The regular dose of the morphine was not given at the time prescribed.	
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>The registered nurses complete initial assessments and an initial care plan on admission. One of six files reviewed (hospital) had an interRAI assessment completed but not within the required timeframes. One of six files (rest home) did not have the long-term care plan completed within 21 days of admission.</p> <p>An interRAI assessment is completed by the registered nurse, at the time of the long-term care plan review and with a change in health condition. Three of five files sampled (one hospital and two rest home), had evidence of a care plan review, however an interRAI assessment was not documented at the time of the review.</p> <p>The general practitioner (GP) reviews residents within 48 hours of admission, if they have not been seen by a medical practitioner within two days of admission. Two of five files (one hospital and one rest home) had not been seen by the GP within 48 hours of admission.</p>	<p>i) One of six files reviewed (hospital level care) for a resident admitted in December did not have an interRAI assessment completed within 21 days of admission.</p> <p>ii) One of six (rest home level care) did not have the long-term care plan completed within 21 days of admission.</p> <p>iii) Three of five files (one hospital and two rest home) did not have an interRAI assessment completed at the time of the long-term care plan review.</p> <p>iv) Two of five files sampled (one hospital and one rest home) had not been seen by the GP within 48 hours of admission.</p>	<p>i) Ensure that all interRAI assessments are completed within the required timeframes.</p> <p>ii) Ensure that all long-term care plans are documented within 21 days of admission.</p> <p>iii) Ensure that the interRAI assessments are completed to inform the review of the long-term care plan.</p> <p>iv) Ensure that all new admissions are seen by the GP within the required timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support</p>	PA Low	Care plans are documented by the RN but not all current interventions are documented and not all	i) Three of six files reviewed (one hospital (tracer) and two rest home - including the rest home tracer)	i) Ensure that interventions documented in the progress notes are transferred to a care

<p>and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>interventions for assessed care needs were documented. There was evidence of the use of short-term care plans for wounds, however the care required for acute changes in health condition (although documented in the progress notes) were not always transferred to a care plan. Healthcare assistants and RNs interviewed were aware of current resident needs. The current care plan template did not allow for easy documentation of interventions, however, progress notes fully described current care being provided.</p>	<p>had interventions documented in the progress notes that were not transferred to a care plan for acute changes in health conditions (for infections and weight loss).</p> <p>ii) Interventions were not documented for all identified care needs in five of six files reviewed (three hospital and two rest home). Intervention shortfalls were identified around manual handling requirements, pressure injury risk, continence management, shortness of breath, CHF, monitoring of blood sugar levels and weight management</p>	<p>plan for all acute changes in health status.</p> <p>ii) Ensure that care plans include all current interventions for care.</p> <p>60 days</p>
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.