# Masonic Care Limited - Glenwood Masonic Hospital

## Current Status: 9 October 2014

**The following summary has been accepted by the Ministry of Health as being an accurate reflection of the** **Surveillance Audit conducted against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) on the audit date(s) specified.**

## General overview

Glenwood Masonic Hospital is owned and operated by Masonic Care Limited, a division of Masonic Villages Trust, alongside three other facilities in the lower North Island. It provides hospital and rest home level care with 45 beds available and 43 beds occupied on the day of audit. The chief executive of Masonic Care Limited is responsible for all facilities, with an onsite facility manager supported by a clinical nurse manager.

One of the six areas for improvement identified at surveillance remains open, with five addressed. Areas for improvement have been identified in relation to care planning and evaluation of care. Areas of continuous improvement have been identified with regard to the complaints management process, orientation of new staff, education planning and the use of quality data to improve service delivery and resident quality of life.

## Audit Summary as at 9 October 2014

Standards have been assessed and summarised below:

### Key

| **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 |
|  | 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 |

### Consumer Rights as at 9 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Organisational Management as at 9 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Continuum of Service Delivery as at 9 October 2014

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

### Safe and Appropriate Environment as at 9 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Restraint Minimisation and Safe Practice as at 9 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

### Infection Prevention and Control as at 9 October 2014

|  |  |  |
| --- | --- | --- |
| 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. |

# HealthCERT Aged Residential Care Audit Report (version 4.2)

## **Introduction**

This report records the results of an audit against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008) of an aged residential care service provider. The audit has been conducted by an auditing agency designated under 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).

It is important that auditors restrict their editing to the content controls in the document and do not delete any content controls or any text outside the content controls.

## **Audit Report**

|  |  |
| --- | --- |
| **Legal entity name:** | Masonic Care Limited |
| **Certificate name:** | Masonic Care Limited - Glenwood Masonic Hospital |

|  |  |
| --- | --- |
| **Designated Auditing Agency:** | The DAA Group Limited |

|  |  |
| --- | --- |
| **Types of audit:** | Surveillance Audit |
| **Premises audited:** | Glenwood Masonic Hospital |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| **Dates of audit:** | **Start date:** | 9 October 2014 | **End date:** | 9 October 2014 |

**Proposed changes to current services (if any):**

|  |  |
| --- | --- |
| **Total beds occupied across all premises included in the audit on the first day of the audit:** | 43 |

## **Audit Team**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Lead Auditor** | XXXXXXXXX | **Hours on site** | 8 | **Hours off site** | 5 |
| **Other Auditors** | XXXXXXXX | **Total hours on site** | 8 | **Total hours off site** | 4 |
| **Technical Experts** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Consumer Auditors** |  | **Total hours on site** |  | **Total hours off site** |  |
| **Peer Reviewer** | XXXXXXX |  |  | **Hours** | 2 |

## **Sample Totals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Total audit hours on site | 16 | Total audit hours off site | 11 | Total audit hours | 27 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Number of residents interviewed | 4 | Number of staff interviewed | 15 | Number of managers interviewed | 2 |
| Number of residents’ records reviewed | 6 | Number of staff records reviewed | 7 | Total number of managers (headcount) | 2 |
| Number of medication records reviewed | 12 | Total number of staff (headcount) | 57 | Number of relatives interviewed | 3 |
| Number of residents’ records reviewed using tracer methodology | 2 |  |  | Number of GPs interviewed | 1 |

## **Declaration**

I, XXXXXXXX, Director of Wellington hereby submit this audit report pursuant to section 36 of the Health and Disability Services (Safety) Act 2001 on behalf of The DAA Group Limited, an auditing agency designated under section 32 of the Act.

I confirm that:

|  |  |  |
| --- | --- | --- |
| a) | I am a delegated authority of The DAA Group Limited | Yes |
| b) | The DAA Group Limited has in place effective arrangements to avoid or manage any conflicts of interest that may arise | Yes |
| c) | The DAA Group Limited has developed the audit summary in this audit report in consultation with the provider | Yes |
| d) | this audit report has been approved by the lead auditor named above | Yes |
| e) | the peer reviewer named above has completed the peer review process in accordance with the DAA Handbook | Yes |
| f) | if this audit was unannounced, no member of the audit team has disclosed the timing of the audit to the provider | Yes |
| g) | The DAA Group Limited has provided all the information that is relevant to the audit | Yes |
| h) | The DAA Group Limited has finished editing the document. | Yes |

Dated Monday, 3 November 2014

## **Executive Summary of Audit**

**General Overview**

Glenwood Masonic Hospital is owned and operated by Masonic Care Limited, a division of Masonic Villages Trust, alongside three other facilities in the lower North Island. It provides hospital and rest home level care with 45 beds available and 43 beds occupied on the day of audit. The chief executive of Masonic Care Limited is responsible for all facilities, with an onsite facility manager supported by a clinical nurse manager.

One of the six areas for improvement identified at surveillance remains open, with five addressed. Areas for improvement have been identified in relation to care planning and evaluation of care. Areas of continuous improvement have been identified with regard to the complaints management process, orientation of new staff, education planning and the use of quality data to improve service delivery and resident quality of life.

**Outcome 1.1: Consumer Rights**

There is evidence to support the environment at Glenwood Masonic Care Ltd is conducive to effective communication.

The complaints management process is known to staff and residents, with policies and procedures to guide management of complaints, with documentation available to capture complaints, compliments and feedback. A complaints register is maintained, with information on all complaints collated and reviewed. The process for ensuring all complaints are satisfactorily resolved has been improved and demonstrates continuous improvement.

**Outcome 1.2: Organisational Management**

A senior management team includes an experienced manager, who is a registered nurse with an annual practising certificate, and an experienced clinical nurse manager. The workforce is a combination of registered nurses, enrolled nurses and caregivers with support staff.

Recruitment processes are well organised and files demonstrating that all staff are interviewed, credentials are confirmed, police checks are completed and orientation is very structured and implemented for all staff. The review and development of the orientation programme is an area of continuous improvement.

The clinical nurse manager is responsible for the staff roster and through ongoing performance review she is able to ensure that the appropriate staffing skill mix is available across all shifts. Policies and procedures are in place to ensure contractual requirements are met. Staff have access to additional staff when resident numbers and residents’ needs increase, as well as agency staff when there are shortfalls.

All caregivers participate in the Aged Care Education (ACE) programme, with support staff soon to enrol in area specific programmes. Nursing staff have access to education and a professional development and recognition programme. Annual mandatory training is provided twice a year with all staff attending. Competencies have been introduced, with additional training focusing on safe medication management. The education plan documents goal, expected outcomes and processes of ongoing review and demonstrates continuous improvement.

There is a culture of quality improvement, with all staff actively engaged in the process. A number of large projects have been implemented including the presentation of rooms, management of falls, and improving access to mandatory training. Feedback from complaints, residents, family members, staff and other health providers is analysed and utilised to seek areas for improvement, with all processes evaluated to ensure the objective has been achieved. Auditing processes enable the facility to review their data and ongoing performance and compliance, along with the opportunity to compare their results with the other facilities within the Masonic Care Group, and externally through a programme that compares results across Australasia. This information is routinely used to review service delivery and the resident and staff experience, whilst also reviewing any incidents that occur. Documentation demonstrates improvements are made. The commitment to the use of quality data to improve the service and the quality of life for residents and staff is an area of continuous improvement.

**Outcome 1.3: Continuum of Service Delivery**

Four of the five previous required improvements at Glenwood Masonic Care Ltd have been addressed; however, one still remains around evaluations. In addition there are two new areas that require improvement identified. There is evidence that all residents’ needs are assessed on admission by the multidisciplinary team, however not all residents have a long term care plan in place within three weeks of admission, and this is identified as requiring improvement. Care plans sighted evidence care required is identified, co-ordinated, planned and reviewed in participation with the resident, although an improvement is required to ensure interventions address assessment findings for all residents.

An activities programme, that includes a wide range of activities and involvement with the wider community, is enjoyed by residents.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents.

Menus are reviewed by a dietitian as meeting nutritional guidelines for older people. Any special dietary requirements and need for feeding assistance or modified equipment is recorded and being met. Residents have a role in menu choice and those interviewed are satisfied with the food service provided.

**Outcome 1.4: Safe and Appropriate Environment**

The facilities at Glenwood Masonic Hospital comply with legislation and have recently been inspected for the renewal of their building warrant of fitness. It is observed that the facilities are well maintained, clean, and tidy and designed to meet the requirements of service delivery. A maintenance manager is in place to oversee the maintenance of the buildings and grounds.

**Outcome 2: Restraint Minimisation and Safe Practice**

Policies and procedures are in place to minimise the use of restraint and to ensure that when restraint is in use it is appropriately monitored and reviewed. Staff receive training in restraint minimisation annually and demonstrate an understanding of the policies and implementation of restraint which addresses a previous required improvement. Enablers are documented when in use.

**Outcome 3: Infection Prevention and Control**

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated and analysed. Surveillance results are reported through all levels of the organisation, including governance.

## **Summary of Attainment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **CI** | **FA** | **PA Negligible** | **PA Low** | **PA Moderate** | **PA High** | **PA Critical** |
| **Standards** | 0 | 14 | 0 | 1 | 2 | 0 | 0 |
| **Criteria** | 4 | 32 | 0 | 1 | 2 | 0 | 0 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **UA Negligible** | **UA Low** | **UA Moderate** | **UA High** | **UA Critical** | **Not Applicable** | **Pending** | **Not Audited** |
| **Standards** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 33 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 62 |

## **Corrective Action Requests (CAR) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** | **Corrective Action** | **Timeframe (Days)** |
| --- | --- | --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Standard 1.3.3: Service Provision Requirements | Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. | PA Low |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.3.3 | 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. | PA Low | Within three weeks of admission the RN completes a long term care plan, based on the collection of comprehensive assessment data; however this is not evidenced in all care plans reviewed and is an area requiring corrective action. | Provide evidence of the long term care plan being completed within required time frames.  | 180 |
| HDS(C)S.2008 | Standard 1.3.6: Service Delivery/Interventions  | Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.6.1 | The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The provision of care and interventions in two of five residents’ files is inconsistent with the residents’ documented needs and desired outcomes.  | Provide evidence that interventions and care provision meets residents’ assessed needs.  | 90 |
| HDS(C)S.2008 | Standard 1.3.8: Evaluation  | Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate |  |  |  |
| HDS(C)S.2008 | Criterion 1.3.8.2 | Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Moderate | Formal care plan evaluations are conducted at least six monthly or as needs change. While the care plans reviewed reflect changes in interventions, in some care plans there is no evidence of evaluations having taken place.  | Provide evidence of documented, customer-focused evaluations which demonstrate the response to interventions and document progress towards meeting residents’ needs and desired outcomes.  | 90 |

## **Continuous Improvement (CI) Report**

| **Code** | **Name** | **Description** | **Attainment** | **Finding** |
| --- | --- | --- | --- | --- |
| HDS(C)S.2008 | Criterion 1.1.13.3 | An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | CI | The facility has reviewed their complaints process, identifying that it was not always clear that the complaint was satisfactorily resolved. A new process has been introduced to ensure that the complainant has received the letter of the outcome and confirms that they are satisfied that their complaint has been resolved. |
| HDS(C)S.2008 | Criterion 1.2.3.6 | Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Glenwood Masonic Hospital demonstrates a commitment to quality improvement by all staff and the utilisation of data to review and improve service delivery and to seek opportunities to improve the quality of life of residents and the work environment for staff. |
| HDS(C)S.2008 | Criterion 1.2.7.4 | New service providers receive an orientation/induction programme that covers the essential components of the service provided. | CI | The orientation programme for all staff has been reviewed to ensure that all staff are appropriately orientated to the facility, policies and procedures and to their role specifically. The process is well documented and allows for feedback at one, three and twelve months and includes the review of and setting of new goals as part of the ongoing performance appraisal process. The process is evaluated individually by the staff. |
| HDS(C)S.2008 | Criterion 1.2.7.5 | A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | CI | The facility has a demonstrated commitment to education with the formation of an education committee with documented goals. Through evaluation of the quality and risk plan, incidents and staff feedback regarding training delivered, the facility has reviewed education delivery and implemented a new system which is reported to have improved attendance, demonstrated higher levels of compliance and increased staff satisfaction. All education delivered or attended is evaluated by staff and reviewed for appropriateness. Ongoing opportunities for education are explored and added to a comprehensive education calendar for all staff. |

# NZS 8134.1:2008: Health and Disability Services (Core) Standards

## **Outcome 1.1: Consumer Rights**

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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.

#### Standard 1.1.9: Communication **(**HDS(C)S.2008:1.1.9)

Service providers communicate effectively with consumers and provide an environment conducive to effective communication.

ARC A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1b.ii; D16.4b; D16.5e.iii; D20.3 ARHSS A13.1; A13.2; A14.1; D11.3; D12.1; D12.3a; D12.4; D12.5; D16.1bii; D16.4b; D16.53i.i.3.iii; D20.3

**Attainment and Risk:** FA

**Evidence:**

The service provided by Glenwood Masonic Care Ltd (Glenwood) is conducive to an environment of effective communication.

Residents and family of Glenwood confirm communication with staff is open, honest and effective. They are always consulted and informed of any untoward event or change in care provision, and are included in care reviews as sighted in files (four hospital and two rest home) reviewed and verified in interviews (three rest home and one hospital resident, three hospital resident families, one clinical manager and two RNs) and sighted during audit.

Communication with relatives is documented in the communication sheet which is kept in the resident’s file (sighted). Incident and accident forms evidence resident and/or family are informed of incidents, when requested. Glenwood has an open disclosure policy which provides guidance to staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the annual education programme (records sighted). Staff confirm they understand that relatives and residents must be informed of any changes in care provision, by the RN.

There are no residents that require interpreting service, however management staff are aware of how to access interpreters if this service should be required.

Staff are identifiable by their name badge and uniforms. Staff introduce themselves to residents upon entering the resident's room (observed).

The District Health Boards contract requirements are met.

##### **Criterion 1.1.9.1 (HDS(C)S.2008:1.1.9.1)**

Consumers have a right to full and frank information and open disclosure from service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.9.4 (HDS(C)S.2008:1.1.9.4)**

Wherever necessary and reasonably practicable, interpreter services are provided.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.1.13: Complaints Management  **(**HDS(C)S.2008:1.1.13)

The right of the consumer to make a complaint is understood, respected, and upheld.

ARC D6.2; D13.3h; E4.1biii.3 ARHSS D6.2; D13.3g

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures are in place to guide the management of residents’ complaints, compliments and feedback. The welcome pack for new residents includes information on the complaints process. Residents are able to make complaints directly through the forms, via the resident advocate or monthly residents’ meetings as well as directly to the CNM or Manager. The management of complaints is included in the orientation programme for new staff and during annual mandatory training programmes for all staff. Staff and residents confirm an understanding of the process regarding complaints and their responsibilities in this process. A complaints log and register is maintained and demonstrates responses to complaints within a timely fashion. Process around ensuring that the complainant is satisfied with the outcome of the complaint process have been reviewed and improved to ensure that the complaint can be closed off and forms the basis for a continuous improvement in 1.1.13.3.

The ARC requirements are met.

##### **Criterion 1.1.13.1 (HDS(C)S.2008:1.1.13.1)**

The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.1.13.3 (HDS(C)S.2008:1.1.13.3)**

An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.

**Attainment and Risk:** CI

**Evidence:**

A complaints log and register is maintained and captures the required information to track the timeframes around responses. The Clinical Nurse Manager (CNM) states that it was not always clear that the complaints had been formally closed off. The CNM confirmed that they have worked off the principle that no news means that they are satisfied. There is evidence that telephone calls and emails are made to seek a final response but this was not always successful. To improve the process and to ensure that there is satisfaction with the outcome, a new letter has been introduced which provides formal acknowledgement that the final letter is received and that the complainant is satisfied with the outcome of their complaint.

**Finding:**

The facility has reviewed their complaints process, identifying that it was not always clear that the complaint was satisfactorily resolved. A new process has been introduced to ensure that the complainant has received the letter of the outcome and confirms that they are satisfied that their complaint has been resolved.

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.2: Organisational Management**

Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

#### Standard 1.2.1: Governance **(**HDS(C)S.2008:1.2.1)

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.

ARC A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.3d; D17.4b; D17.5; E1.1; E2.1 ARHSS A2.1; A18.1; A27.1; A30.1; D5.1; D5.2; D5.3; D17.5

**Attainment and Risk:** FA

**Evidence:**

Masonic Villages Trust is governed by a board of trustees which currently has 10 members with an appropriate mix of skill and expertise in the trustees. There is an ability to co-opt additional members and expertise as required. Glenwood Masonic Hospital (GMH) is governed by a smaller board of three trustee members with responsibility under the umbrella of Masonic Care Limited with the Chief Executive Officer (CEO) responsible for all residential facilities within the Masonic Trust. He has been in his position for 10 years, and has an office onsite at Woburn. The board meets monthly, with the CEO confirming that he meets with the chair of the board monthly outside of the planned board meeting. The CEO is a director of the NZ Aged Care Association which supports keeping abreast of health sector issues and the potential impacts on facilities.

The Masonic Care Limited Strategic Business plan (2011-2016) identifies values (benevolence, charity, respect, excellence and integrity), scope and organisational goals to be sustainable, to provide resident centred care, to achieve ongoing quality improvements and to be the best place to work. Each goal identifies specific strategies as well as indicators to identify achievement against the goals. The plan identifies the current sector environment including future drivers for change which is considered in terms of supporting business continuity.

The plan is reviewed annually with the CEO confirming he is currently preparing for the scheduled November 2014 review.

Day to day operational management is provided by a manager (interviewed by telephone) who is a registered nurse who holds an annual practising certificate, a Masters in Nursing, and has completed business and management studies. She has been in her position since the facility was opened in 2010. The clinical team is led by an experienced Clinical Nurse Manager who confirms she has been in her position since December 2012.

The ARC requirements are met.

##### **Criterion 1.2.1.1 (HDS(C)S.2008:1.2.1.1)**

The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.1.3 (HDS(C)S.2008:1.2.1.3)**

The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.3: Quality And Risk Management Systems **(**HDS(C)S.2008:1.2.3)

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.

ARC A4.1; D1.1; D1.2; D5.4; D10.1; D17.7a; D17.7b; D17.7e; D19.1b; D19.2; D19.3a.i-v; D19.4; D19.5 ARHSS A4.1; D1.1; D1.2; D5.4; D10.1; D16.6; D17.10a; D17.10b; D17.10e; D19.1b; D19.2; D19.3a-iv; D19.4; D19.5

**Attainment and Risk:** FA

**Evidence:**

The 2013/2014 Risk Management Plan clearly outlines the roles and responsibilities regarding risk in areas such as clinical documentation, quality and risk management, health and safety, administration, human resources, financial, security, informed consent, medication management, restraint, communication and information technology. The Continuous Quality Improvement Plan 2013/2014 is noted to link to the above risks and the business and strategic plan. Goals and objectives are identified, with actions, responsibilities, outcomes and expected dates documented.

Policies and procedures are developed in line with legislation and best practice, with a document review process in place. At GMH there is only one hard copy of the policies and procedures held by the CNM who is responsible for document control. Policies, forms and procedures are accessed by a common computer shared drive which ensures the most current document is in use. The CNM has created a Health Record Policy which helps staff navigate to finding the document needed.

Processes are in place to support the identification of risks and hazards, including responsibilities, with staff interviewed confirming an understanding of the process for reporting and indicating that they routinely used the documented processes. It was observed that hazards specific to each area (such as kitchen, laundry, recreation room) were visible in the areas.

Internal and external auditing and benchmarking is undertaken, with a record of all audits, and benchmarking reports observed. The CNM confirmed that the external results are reviewed by the management team with action plans developed if required. There is evidence that there is a strong commitment to quality assurance and quality improvement with staff participating in a number of projects which have led to improvements in service delivery, staff satisfaction, quality of life for residents, and the creation of a workplace that is safe and reflects a culture of teamwork and commitment to quality care delivery. The facility routinely utilises review/audit processes and a cycle of quality improvement whereby data is analysed and leads to improvements in service delivery which is then evaluated to demonstrate improvements. This forms the basis for a continuous improvement in 1.2.3.6.

The ARC requirements are met.

##### **Criterion 1.2.3.1 (HDS(C)S.2008:1.2.3.1)**

The organisation has a quality and risk management system which is understood and implemented by service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.3 (HDS(C)S.2008:1.2.3.3)**

The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.4 (HDS(C)S.2008:1.2.3.4)**

There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.5 (HDS(C)S.2008:1.2.3.5)**

Key components of service delivery shall be explicitly linked to the quality management system.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.6 (HDS(C)S.2008:1.2.3.6)**

Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.

**Attainment and Risk:** CI

**Evidence:**

The facility has a programme in place that includes internal audit and external audit by an Australasian organisation. The commitment to quality improvement is demonstrated through active programmes of learning by staff and the utilisation of this training to inform and develop quality improvement initiatives. Any issues identified as requiring improvement are recorded and addressed via a quality improvement approach.

Examples include improvement of the diet schedule to include nutritional supplements and the appropriate recording of when these supplements have been provided to the resident; updating the policy and documentation for the GP clinics in response to an issue raised by the GP; processes to ensure resident agreements are signed. Larger projects have included training on ‘lean thinking’ principles which resulted in a review of the way in which rooms were presented and the information brochures about the facility. Feedback from staff on this initiative indicated that each staff member had a role in the preparation of the room and that the processes introduced have improved the presentation of rooms and was a process that continues to be reviewed to ensure high standards are maintained. The facility has participated in a collaborative project with the DHB (supported by the Health Safety and Quality Commission) to reduce harm from falls. In reviewing their management of falls, a daily falls calendar has been introduced along with a falls map and wheel to support the analysis of falls data. ‘Frequent fallers’ are further reviewed to establish patterns, causative factors, with evidence of ongoing review when new strategies are implemented. Data was sighted that confirmed that resident weights had stabilised for those residents who were receiving regular supplements. The falls project demonstrated that there had been a reduction in the number of falls recorded as well as process in place to analyse fall patterns and to implement strategies that were individualised to the residents.

**Finding:**

Glenwood Masonic Hospital demonstrates a commitment to quality improvement by all staff and the utilisation of data to review and improve service delivery and to seek opportunities to improve the quality of life of residents and the work environment for staff.

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.7 (HDS(C)S.2008:1.2.3.7)**

A process to measure achievement against the quality and risk management plan is implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.8 (HDS(C)S.2008:1.2.3.8)**

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.3.9 (HDS(C)S.2008:1.2.3.9)**

Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:
(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;
(b) A process that addresses/treats the risks associated with service provision is developed and implemented.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.4: Adverse Event Reporting  **(**HDS(C)S.2008:1.2.4)

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.

ARC D19.3a.vi.; D19.3b; D19.3c ARHSS D19.3a.vi.; D19.3b; D19.3c

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures are sighted which provide information on the management of adverse events, with the CNM confirming an understanding of their statutory and regulatory requirements for reporting. (The CNM and Manager confirmed that the Police have recently initiated an investigation into a resident’s recent death, with staff interviewed the week prior to audit. They are currently awaiting information on how this is to be progressed). There is evidence sighted documenting the process around a Health and Disability Commissioner review with the complaint closed with no further action required.

The CNM confirmed that a close relationship with the portfolio manager at the DHB is maintained. An incident reporting system is in place with all incidents documented and staff interviews confirming the utilisation of the system to document any adverse event within the facility, including staff incidents and accidents.

This incident reporting process is closely linked to the open disclosure policy and ensures that all residents and designated contacts are informed of any incidents. Incident forms are reviewed either on the day of or the next day of a reported incident by the CNM, with actions documented and further evaluated if required. Incidents are reviewed within the clinical, health and safety and management meetings. Where improvement is required, quality improvement processes are initiated.

The ARC requirements are met.

##### **Criterion 1.2.4.2 (HDS(C)S.2008:1.2.4.2)**

The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.4.3 (HDS(C)S.2008:1.2.4.3)**

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.7: Human Resource Management  **(**HDS(C)S.2008:1.2.7)

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.

ARC D17.6; D17.7; D17.8; E4.5d; E4.5e; E4.5f; E4.5g; E4.5h ARHSS D17.7, D17.9, D17.10, D17.11

**Attainment and Risk:** FA

**Evidence:**

Human resource management processes are supported by an Administration Coordinator who has put systems in place to ensure the appropriate information is collected such as annual practising certificates and evidence of qualifications. Policies and documentation for the recruitment process have been standardised, with personnel files reviewed that demonstrate the policies have been implemented and the appropriate documentation is available, including evidence of qualifications, annual practising certificates for nursing and medical staff, as well as pharmacists, podiatrist and physiotherapist, reference checks, police vetting, contracts, performance appraisals and position descriptions.

Orientation programmes are available for all staff, with the programme recently reviewed and redeveloped to ensure that the staff are orientated appropriately to the facility, the policies and procedures, to other staff with responsibilities (such as infection control, health and safety, fire) and to their role specifically. Aspects of competence assessment are included. Staff have the ability to review their orientation with the CNM at 1 month, 3 months and then at 12 months, with a focus on the development of goals and identifying support required moving forward. The orientation programme has achieved a continuous improvement reflecting development and ongoing evaluation of the programme.

The facility has a strong commitment to education for all staff. An education committee has been established, the facility has a dedicated educator and an education plan with documented goals. All caregivers are required to participate in a formal education programme, which is soon to be extended to other support staff. Annual mandatory training has been reviewed with changes to the programme demonstrating increased attendance, and staff satisfaction for the training programme. Ongoing evaluation of all training occurs. A continuous improvement is identified for the education programme.

The ARC requirements are met.

##### **Criterion 1.2.7.2 (HDS(C)S.2008:1.2.7.2)**

Professional qualifications are validated, including evidence of registration and scope of practice for service providers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.3 (HDS(C)S.2008:1.2.7.3)**

The appointment of appropriate service providers to safely meet the needs of consumers.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.4 (HDS(C)S.2008:1.2.7.4)**

New service providers receive an orientation/induction programme that covers the essential components of the service provided.

**Attainment and Risk:** CI

**Evidence:**

The orientation programme was reviewed in 2013 and completed in February 2014. Feedback from staff demonstrated some gaps in the orientation process which has resulted in redevelopment of the orientation workbook, with job specific orientation further documented. The CNM described a comprehensive orientation which included designated roles for orientation, a one month follow up with the CNM to sign off the checklists and to develop an action plan. A further appraisal is conducted at 3 months and documents performance, goals for development, and any training requirements needed to ensure that the staff member is competent in their role. The annual performance review process is then initiated from this meeting. Through the orientation process, staff meet with the quality coordinator, fire and emergency officer, infection control, restraint and health and safety coordinators, and the educator. They are also required to view a health and safety DVD and complete an education needs analysis.

Staff interviewed confirmed that the programme is excellent, orientates them fully to the facility and to their roles and ensures that they feel safe and competent to work. A process of evaluation is built into the orientation programme, with any issues identified reviewed by the quality team to further improve the documentation. Feedback viewed in the documents in personnel files further confirms staff satisfaction with the process.

**Finding:**

The orientation programme for all staff has been reviewed to ensure that all staff are appropriately orientated to the facility, policies and procedures and to their role specifically. The process is well documented and allows for feedback at one, three and twelve months and includes the review of and setting of new goals as part of the ongoing performance appraisal process. The process is evaluated individually by the staff.

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.2.7.5 (HDS(C)S.2008:1.2.7.5)**

A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.

**Attainment and Risk:** CI

**Evidence:**

An education committee has been established and has developed a plan identifying the education goals for 2014/2015, with the facility having a dedicated educator, who, along with the CNM, is registered as an ACE assessor. Caregivers are required to complete ACE training, with this soon to be extended to support staff such as kitchen and cleaning staff. Registered nurses and enrolled nurses participate in the local DHB professional development and recognition programme.

Mandatory training has been reviewed following low attendance rates in previous years. The new programme is now delivered in a two day mandatory training programme for all staff that is provided twice a year, with staff rostered to attend each year. Attendance records demonstrate 100% attendance. Inservice education programmes are provided, with records demonstrating, and the CNM confirming that attendance rates are high. Staff interviewed confirmed that the previous delivery was ineffective, time consuming and did not always meet their needs. They stated that the new delivery is better managed and supports their attendance and their learning alongside their colleagues.

The facility demonstrates that they are responsive to issues and use the education programme as a means of supporting quality improvement. For example when it was identified that there were a large number of medication errors, the medication competency process was reviewed and changes implemented. Medication delivery is further supported by staff having access to an education programme of modules focusing on safe medication management. Staff complete work activities and attend monthly inservice education. Data demonstrates there has been a 50% reduction in medication errors in a 6 month timeframe.

To ensure that staff maintain competence in their roles, a programme of competencies has been developed for the registered and enrolled nurses, with a similar programme in development for the caregivers. Staff training records are maintained to demonstrate attendance at established training programmes, inservice sessions and externally provided education such as conferences, DHB study days and palliative care education.

**Finding:**

The facility has a demonstrated commitment to education with the formation of an education committee with documented goals. Through evaluation of the quality and risk plan, incidents and staff feedback regarding training delivered, the facility has reviewed education delivery and implemented a new system which is reported to have improved attendance, demonstrated higher levels of compliance and increased staff satisfaction. All education delivered or attended is evaluated by staff and reviewed for appropriateness. Ongoing opportunities for education are explored and added to a comprehensive education calendar for all staff.

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.2.8: Service Provider Availability  **(**HDS(C)S.2008:1.2.8)

Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.

ARC D17.1; D17.3a; D17.3 b; D17.3c; D17.3e; D17.3f; D17.3g; D17.4a; D17.4c; D17.4d; E4.5 a; E4.5 b; E4.5c ARHSS D17.1; D17.3; D17.4; D17.6; D17.8

**Attainment and Risk:** FA

**Evidence:**

At interview, the CNM confirms that policies and procedures are in place to ensure that the service provider levels and skill mix is appropriate. She confirms that as she is responsible for orientation of new staff, annual performance reviews and the delivery of education, she uses this knowledge in the development of the staff roster. Documented processes for accessing agency staff is sighted and confirms that all attempts to maintain the continuity of service delivery are implemented, with staff able to access agency staff when there is a staffing shortfall.

Rosters were reviewed in July in response to increasing resident numbers and acuity, and feedback from staff regarding workloads resulted in the introduction of additional shifts to provide support at peak times of activity. Staff also have access to an additional caregiver for 8 hours across a given 24 hour period with this staff member deployed when acuity and workload requires additional staff.

The education plan and policies and procedures sighted ensures that staff participate in education and training, and the development of appropriate skills to meet the requirements of safe service delivery. At interview, staff confirm that training is provided and they ensure that they are competent to fill service requirements. They confirmed that management were responsive to identified needs, staffing and education requirements.

The ARC requirements are met.

##### **Criterion 1.2.8.1 (HDS(C)S.2008:1.2.8.1)**

There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.3: Continuum of Service Delivery**

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.

#### Standard 1.3.3: Service Provision Requirements **(**HDS(C)S.2008:1.3.3)

Consumers receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals.

ARC D3.1c; D9.1; D9.2; D16.3a; D16.3e; D16.3l; D16.5b; D16.5ci; D16.5c.ii; D16.5e ARHSS D3.1c; D9.1; D9.2; D16.3a; D16.3d; D16.5b; D16.5d; D16.5e; D16.5i

**Attainment and Risk:** PA Low

**Evidence:**

Each stage of the service provision at Glenwood is undertaken by a suitably qualified provider and is developed with the resident and their family/whanau.

Within 24 hours of admission the initial assessment process is undertaken by the registered nurse (RN) and includes gathering data from the resident, their family/nominated representative, the needs assessment and co-ordination service and/or previous providers of personal care services. Data gathered informs the initial documented plan of care the staff require to meet the resident’s immediate needs. A medical assessment is conducted by the resident’s general practitioner (GP) within 24 hours of admission and the medical treatment programme required by the resident is documented. This serves as the basis for care planning to cover a period of up to three weeks.

Within three weeks of admission the RN completes a long term care plan, based on the collection of comprehensive assessment data; however this is not evidenced in two of five care plans reviewed and is an area requiring corrective action.

The long term care plan directs the care required to meet the resident’s need and desired outcome. Progress notes, recording the daily progress of the resident, are documented by the care staff providing the care and the RN (where RN input is required) each shift.

The ongoing assessments, interventions and evaluation is completed and documented by the RN in consultation with the resident, family and allied professionals as residents’ needs change. The care plan is evaluated every six months or as needs change to ensure the appropriate care is provided and the residents’ desired outcomes are being met.

A previous corrective action concerning the timeframe for the GP review of residents has been addressed. Ongoing medical review is undertaken either monthly or three monthly if the medical practitioner deems the resident to be stable. The resident’s medication is reviewed three monthly or as needs change and this is conducted by the GP.

Family contact is documented in the family contact record.

Evidence of the above is sighted in files reviewed and verified by interview. Residents and family/whanau are happy with the quality of care that is provided as evidenced by interviews.

Evidence sighted at Glenwood verifies residents receive services provided by competent staff. Registered and enrolled nurses practicing certificates, medication competencies, training records and first aid certificates are sighted. The registered nurse acts as the resident’s case manager and is responsible for planning, reviewing and overseeing all aspects of the residents care. Caregivers with experience, education and training in aged care (as evidenced by training records) provide most of the direct provision of care. The in-service education programme (sighted) contains the required education for the staff to meet contractual requirements.

The cooks and kitchen assistants have qualifications in food safety training. The activities programme is managed by a trained diversional therapist with assistance from a trainee diversional therapist. A contracted physiotherapist and podiatrist provide services to the residents. The annual practising certificates (APCs) are sighted for all other staff and contracted staff that require an APC.

Evidence sighted at Glenwood verifies the service provides continuity. Residents can be attended to by their GP of choice or the facility GP/nurse practitioner who visit every Thursday. A monthly clinic that includes the facility GP, clinical manager, manager and the physiotherapist, reviews residents with concerns on an ongoing basis. The RN’s oversees the residents whose care they are responsible for planning. A verbal handover by the RN occurs at the beginning of each shift to ensure all staff is familiar with the residents’ needs.

Health professionals are allocated the residents they are to deliver the daily care to, under the guidance of the RN, and write in the resident's progress notes at the end of each shift. Resident notes are integrated and demonstrate input from a variety of health professionals, and are responsive to the assessed needs of the resident, including amendments to care plans and goals for the resident as appropriate. Timely access to other health providers is evident in files reviewed.

The District Health Board (DHB) contract requirements are not met.

Tracer 1 – Hospital resident

*XXXXXX This information has been deleted as it is specific to the health care of a resident.*

Tracer 2 - Rest home resident.

*XXXXXX This information has been deleted as it is specific to the health care of a resident.*

##### **Criterion 1.3.3.1 (HDS(C)S.2008:1.3.3.1)**

Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.3 (HDS(C)S.2008:1.3.3.3)**

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.

**Attainment and Risk:** PA Low

**Evidence:**

In two of five files reviewed there is no evidence of a long term care plan being completed within three weeks of admission.

**Finding:**

Within three weeks of admission the RN completes a long term care plan, based on the collection of comprehensive assessment data; however this is not evidenced in all care plans reviewed and is an area requiring corrective action.

**Corrective Action:**

Provide evidence of the long term care plan being completed within required time frames.

**Timeframe (days):** 180 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.3.4 (HDS(C)S.2008:1.3.3.4)**

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.6: Service Delivery/Interventions  **(**HDS(C)S.2008:1.3.6)

Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.

ARC D16.1a; D16.1b.i; D16.5a; D18.3; D18.4; E4.4 ARHSS D16.1a; D16.1b.i; D16.5a; D16.5c; D16.5f; D16.5g.i; D16.6; D18.3; D18.4

**Attainment and Risk:** PA Moderate

**Evidence:**

The care and services at Glenwood are delivered in a safe and respectful manner although the provision of care in two of five residents’ files is inconsistent with the residents’ documented physical, social, spiritual and emotional needs and desired outcomes. A resident who is noted to have a significant weight loss has no interventions sighted to acknowledge or manage that loss. A resident with challenging behaviour has no long term care plan (refer 1.3.3) and has a behaviour monitoring chart yet no behaviour management plan. This is an area requiring corrective action.

A previous corrective action around wound management has been addressed and interventions sighted are detailed, accurate and meet current best practice standards.

The GP interviewed expressed overall satisfaction with the service, though expressed concerns around not always getting good detailed assessment data from staff familiar with the particular resident when doing three monthly reviews. This is an area recommended to be addressed with the GP and has been discussed with the Clinical Manager at audit.

Interviews with residents and family/whanau members expressed satisfaction with the care provided.

There are sufficient supplies of equipment that complies with best practice guidelines and meets the resident’s needs (sighted).

The DHB contract requirements are not met.

##### **Criterion 1.3.6.1 (HDS(C)S.2008:1.3.6.1)**

The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.

**Attainment and Risk:** PA Moderate

**Evidence:**

A resident who has lost weight has no interventions sighted to acknowledge or manage the weight loss. A resident with challenging behaviour has a behaviour monitoring chart, yet no behaviour management plan.

**Finding:**

The provision of care and interventions in two of five residents’ files is inconsistent with the residents’ documented needs and desired outcomes.

**Corrective Action:**

Provide evidence that interventions and care provision meets residents’ assessed needs.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.7: Planned Activities **(**HDS(C)S.2008:1.3.7)

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.

ARC D16.5c.iii; D16.5d ARHSS D16.5g.iii; D16.5g.iv; D16.5h

**Attainment and Risk:** FA

**Evidence:**

The activities programme at Glenwood is provided by a trained diversional therapist and a trainee diversional therapist with the assistance of volunteers. The programme runs Monday to Friday. A programme is also organised to cover the weekends and is organised by care staff. An additional ‘special programme’ designed by the diversional therapist runs on a Monday and Wednesday for ‘high need’ residents in the hospital and includes one to one activities. Photographs around the facility offer insight into the events that have taken place.

On admission, residents are assessed to ascertain their needs and appropriate activity requirements. The activities assessments and plans include the resident’s preferences, social history, and past and present interests. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. In addition to the activities assessment the physiotherapist’s assessment/plan is also incorporated into specific resident’s activity plans. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in the activity and physiotherapist’s assessment data.

Activities reflect ordinary patterns of life and include normal community activities (eg, bus outings, visiting entertainers, and visits to the local Returned Services Association club, senior citizens clubs, church services and home visits). Family/whanau and friends are welcome to attend all activities and are welcome to visit their relatives. Group activities are developed according to the needs and preferences of the residents who choose to participate.

Individual activity assessments are updated or reviewed at least three monthly with a monthly summary of the resident’s response to the activities, level of interest and participation recorded. The goals are developed with the resident and their family, where appropriate.

A residents’ meeting is held four times per year and is run by the residents’ advocate with the diversional therapist taking the minutes. Meeting minutes evidence that the activities programme is discussed and that management are responsive to requests. Residents and family interviews verify satisfaction with the activities offered. The diversional therapist (interviewed) reports feedback is sought from residents during and after activities.

The DHB contract requirements are met.

##### **Criterion 1.3.7.1 (HDS(C)S.2008:1.3.7.1)**

Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.8: Evaluation  **(**HDS(C)S.2008:1.3.8)

Consumers' service delivery plans are evaluated in a comprehensive and timely manner.

ARC D16.3c; D16.3d; D16.4a ARHSS D16.3c; D16.4a

**Attainment and Risk:** PA Moderate

**Evidence:**

Evaluation of residents’ care is undertaken on a daily basis and documented in the progress notes. If any change is noted it is reported to the RN, who may contact the GP if requested. Family/whanau are kept informed of changes.

Formal care plan evaluations are conducted at least six monthly or as needs change. Evaluation measures the degree of achievement or response of each resident related to their goals six monthly. While the care plans reviewed reflect changes in interventions, four of five care plans reviewed have no documented evidence of evaluations. This was a previous corrective action and remains in place. A new care plan is at present being integrated into practice at Glenwood and where in place (an additional two files are reviewed) evidences where progress is different from expected, the service responds by initiating changes to the service delivery plan.

A short term care plan is initiated for short term concerns such as infections, wound care, changes in mobility and the resident’s general condition

The RN undertakes and reviews all care plans at least every six months or when needed. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process.

Resident and family interviews, verify they are included and informed of all care plan updates and changes.

The DHB contract requirements are not met.

##### **Criterion 1.3.8.2 (HDS(C)S.2008:1.3.8.2)**

Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.

**Attainment and Risk:** PA Moderate

**Evidence:**

Four of five care plans reviewed have no documented evidence of evaluations. A new care plan is at present being integrated into practice at Glenwood and where in place (an additional two files are reviewed) evidences where progress is different from expected, the service responds by initiating changes to the service delivery plan.

**Finding:**

Formal care plan evaluations are conducted at least six monthly or as needs change. While the care plans reviewed reflect changes in interventions, in some care plans there is no evidence of evaluations having taken place.

**Corrective Action:**

Provide evidence of documented, customer-focused evaluations which demonstrate the response to interventions and document progress towards meeting residents’ needs and desired outcomes.

**Timeframe (days):** 90 *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.8.3 (HDS(C)S.2008:1.3.8.3)**

Where progress is different from expected, the service responds by initiating changes to the service delivery plan.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.12: Medicine Management  **(**HDS(C)S.2008:1.3.12)

Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.

ARC D1.1g; D15.3c; D16.5e.i.2; D18.2; D19.2d ARHSS D1.1g; D15.3g; D16.5i..i.2; D18.2; D19.2d

**Attainment and Risk:** FA

**Evidence:**

The Medication Management Policy is comprehensive and identifies all aspects of medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal and medicine reconciliation in order to comply with legislation, protocols and guidelines.

Medicines for residents are received from the pharmacy in the Douglas Pharmaceuticals Medico Pak delivery system. A safe system for medicine management is observed on the day of audit. All staff who administer medicines have current medication competencies (sighted). The staff observed demonstrate good knowledge and have a clear understanding of their roles and responsibilities related to each stage of medicine management.

Controlled drugs are stored in a separate locked cupboard. Controlled drugs, when dispensed are checked by two medication competent nurses (one a RN) for accuracy in dispensing. The controlled drug register evidences weekly stock checks with the last six monthly pharmacy stock take and reconciliation recorded.

The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.

The medicine prescription is signed individually by the GP. The GP’s signature and date are recorded on the commencement and discontinuation of medicines. Residents’ photos, allergies and sensitivities are recorded on the medicine chart. Sample signatures are documented. All medicine charts reviewed have fully completed medicine prescriptions and have signing sheets including approved abbreviations when a medicine has not been given. The three monthly GP review is recorded on the medicine chart.

There are no residents who self-administer their medicines at the time of audit.

Medication errors are reported to the RN, recorded on an incident form, investigated and analysed. The resident and/or the designated representative are advised. A previous corrective action around the management of staff and medication errors has been addressed. The clinical nurse manager monitors to ensure all staff who administer medications have current competencies. Education programmes around safe medication administration have been implemented at Glenwood, and evidence is sighted to support the effectiveness of this programme (refer 1.2.7.5). There is a defined process for analysis and management of medication errors involving staff.

RNs and enrolled nurses (ENs) are assessed for medication competency yearly (sighted).

Standing orders are used at Glenwood. The written authorisation (sighted) is signed by the resident’s GP and identifies the directions and clear indications for each medicines use. The standing order specifies the medicines that may be administered under the standing order, the treatment and condition to which the order applies, the recommended dose range, the number of doses the standing order allows, the contraindications for use, the method of administration and the documentation required. The standing order authorisation is reviewed yearly.

The DHB contact requirements are met.

##### **Criterion 1.3.12.1 (HDS(C)S.2008:1.3.12.1)**

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.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.3 (HDS(C)S.2008:1.3.12.3)**

Service providers responsible for medicine management are competent to perform the function for each stage they manage.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.5 (HDS(C)S.2008:1.3.12.5)**

The facilitation of safe self-administration of medicines by consumers where appropriate.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.12.6 (HDS(C)S.2008:1.3.12.6)**

Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

#### Standard 1.3.13: Nutrition, Safe Food, And Fluid Management **(**HDS(C)S.2008:1.3.13)

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.

ARC D1.1a; D15.2b; D19.2c; E3.3f ARHSS D1.1a; D15.2b; D15.2f; D19.2c

**Attainment and Risk:** FA

**Evidence:**

The food, fluid and nutritional requirements of the residents at Glenwood are provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s documented assessment of the planned menu, that changes seasonally (sighted).

Training records verify the cook and kitchen staff are trained in food and hygiene safety.

Ecolab monitor chemical use, cleaning and food safety in the kitchen and inform the facility with monthly reports and recordings. A cleaning schedule is sighted and verifies evidence of compliance.

There is evidence to support sufficient food is ordered and prepared to meet the residents’ recommended nutritional requirements.

A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident’s nutritional needs are sighted. Evidence of resident satisfaction with meals is verified by resident and family/whanau interviews and in resident meeting minutes.

There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed, sighted and roster reviewed. The dining rooms are clean, warm, light and airy to enhance the eating experience

Food is ordered by the cook on a weekly basis. Fruit and vegetables are ordered twice weekly depending on need and availability and meats and fish are ordered as required.

When food is delivered it is checked for ‘use by date’ and damage then stored in well organised and appropriately temperature controlled storage.

Fridge, freezer, and cooked meat temperatures are monitored daily. Records sighted verify records within accepted parameters.

Raw meat is stored at the bottom of the fridge and is completely thawed before cooking

Any leftovers are covered and labelled with the date/time/contents. Leftovers are not reheated more than once. Leftovers are discarded if older than two days.

The DHB contract requirements are met.

##### **Criterion 1.3.13.1 (HDS(C)S.2008:1.3.13.1)**

Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.2 (HDS(C)S.2008:1.3.13.2)**

Consumers who have additional or modified nutritional requirements or special diets have these needs met.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 1.3.13.5 (HDS(C)S.2008:1.3.13.5)**

All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 1.4: Safe and Appropriate Environment**

Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures 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.

#### Standard 1.4.2: Facility Specifications  **(**HDS(C)S.2008:1.4.2)

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.

ARC D4.1b; D15.1; D15.2a; D15.2e; D15.3; D20.2; D20.3; D20.4; E3.2; E3.3e; E3.4a; E3.4c; E3.4d ARHSS D4.1c; D15.1; D15.2a; D15.2e; D15.2g; D15.3a; D15.3b; D15.3c; D15.3e; D15.3f; D15.3g; D15.3h; D15.3i; D20.2; D20.3; D20.4

**Attainment and Risk:** FA

**Evidence:**

The facility’s building warrant of fitness expired 27 July 2014, with email evidence provided which confirms that the required inspections was undertaken, however there has been a delay in the issuing of the certificate. The buildings are observed to be well maintained, with maintenance records confirming a programme of maintenance and processes for identifying any maintenance issues.

The ARC requirements are met.

##### **Criterion 1.4.2.1 (HDS(C)S.2008:1.4.2.1)**

All buildings, plant, and equipment comply with legislation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

# NZS 8134.2:2008: Health and Disability Services (Restraint Minimisation and Safe Practice) Standards

## **Outcome 2.1: Restraint Minimisation**

Services demonstrate that the use of restraint is actively minimised.

#### Standard 2.1.1: Restraint minimisation **(**HDS(RMSP)S.2008:2.1.1)

Services demonstrate that the use of restraint is actively minimised.

ARC E4.4a ARHSS D16.6

**Attainment and Risk:** FA

**Evidence:**

Policies and procedures are in place to support restraint minimisation and the implementation of enablers or restraint when required. Staff training records demonstrate that restraint minimisation is a component of the annual mandatory training programme, with staff at interview confirming their understanding of the process, the requirements, and their responsibilities, and attendance at the training. They were able to confirm an understanding of enablers and restraint, providing examples of the use of bed rails as an enabler and as a restraint. The restraint register demonstrates that through the process of assessment and evaluation, all attempts are made to avoid the use of restraints.

The ARC requirements are met.

##### **Criterion 2.1.1.4 (HDS(RMSP)S.2008:2.1.1.4)**

The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

## **Outcome 2.2: Safe Restraint Practice**

Consumers receive services in a safe manner.

#### Standard 2.2.3: Safe Restraint Use **(**HDS(RMSP)S.2008:2.2.3)

Services use restraint safely

ARC D5.4n ARHSS D5.4n, D16.6

**Attainment and Risk:** FA

**Evidence:**

A previous area requiring improvement in 2.2.3.6 has been addressed with education records sighted demonstrating that all staff have attended education sessions on restraint minimisation and safe practice. New staff have access to this in their orientation. Refer to comments in 2.1.1.

# NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards

#### Standard 3.5: Surveillance **(**HDS(IPC)S.2008:3.5)

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.

**Attainment and Risk:** FA

**Evidence:**

In line with the Glenwood’s Infection Control Policy, monthly surveillance is occurring. The type and frequency of surveillance is as determined by the infection control programme. All new incidents of urine, chest, eye, gastro-intestinal and soft tissue infections occurring each month are recorded on an infection report form. Residents with infections, as defined by specific criteria, has management of that infection documented on a short term care plan and are discussed at handover to ensure caregivers are familiar with the care required by the resident, as verified by file reviews and ten clinical staff interviews. Infection report forms are collated each month by the infection control nurse and analysed to identify any significant trends or possible causative factors (sighted).

Incidents of infections are presented at the monthly staff meetings and any actions required are implemented, as evidenced by records and verified by staff interviews. The infection control committee meets two monthly and reviews infection figures and audit results. Infection rates are entered into the Quality Performance System (QPS) data base and benchmarked against other facilities (sighted). Findings are discussed at the company’s quality meeting that includes their other three facilities, with any necessary requirements discussed and actioned.

A recent Norovirus outbreak in July-2014 had three confirmed cases out of six possible cases. The situation was quickly contained and resolved.

##### **Criterion 3.5.1 (HDS(IPC)S.2008:3.5.1)**

The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*

##### **Criterion 3.5.7 (HDS(IPC)S.2008:3.5.7)**

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.

**Attainment and Risk:** FA

**Evidence:**

**Finding:**

**Corrective Action:**

**Timeframe (days):**  *(e.g. for 1 week choose 7, for 1 month choose 30, for 6 months choose 180, etc.)*