Whitehaven Healthcare Limited

Introduction

This report records the results of a Provisional 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:	Whitehaven Healthcare Limited
Premises audited:	Glendale Retirement Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 December 2014 End date: 10 December 2014

Proposed changes to current services (if any): The service no longer provides hospital level care.

Total beds occupied across all premises included in the audit on the first day of the audit: 24

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.

General overview of the audit

Glendale retirement home is situated in Dunedin. A provisional audit was conducted to assess a prospective new owner of Glendale and to assess the current status of the service prior to purchase. Glendale is certified to provide rest home level care. There is a temporary manager in place that is experienced in aged care management, having been a previous owner/manager from 2005 – 2011. Building work to remodel and build eight new rooms at the facility has been stalled since September 2013 with a number of unfinished areas. As a result of demolition work conducted prior to building, the service has decreased from 28 to 26 beds. There were 24 rest home level residents accommodated on the day of audit. Residents and families advise that the staff have continued to provide a high standard of care and support despite the change in management, unfinished building work and changes to the layout of the facility.

The prospective owner advised that he intends to complete the building work as soon as possible. The prospective owner intends to be part of the management team alongside the manager, quality coordinator and two business mentors with rest home ownership experience. Staffing levels, quality system, policies and procedures will remain unchanged until a review has been conducted.

This provisional audit has identified that improvements are required around aspects of the quality programme, ensuring timely review of residents by a registered nurse following incidents and accidents, providing registered nurse cover as per contractual requirements, aspects of human resource management and the education programme, dating and signing entries in to records, completion of care at required times, aspects of medication management, completion of unfinished building work, servicing of equipment, monitoring of hot water temperatures, conducting fire drills and maintaining an up to date fire evacuation scheme, and conducting the annual review of the infection control programme.

Consumer rights

Glendale retirement home has strived 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 (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Policies are implemented to support residents' rights. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Informed consent processes are followed and residents' clinical files reviewed evidence informed consent is obtained. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices. 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

Glendale retirement home is certified to provide rest home level care. There were 24 residents on the day of audit. The previous owner of Glendale has been placed in receivership and a temporary manager was appointed in November 2014. The prospective owner was interviewed to establish preparedness in owning and operating Glendale. This person has experience in financing rest homes. His intention is to appoint a permanent full time manager for Glendale. The current temporary manager is experienced in aged care management and is familiar with Glendale. A registered nurse is employed for 30 hours per week to provide clinical oversight. There is a quality coordinator who has been responsible for the implementation of the quality and risk management programme. 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. Improvements are required whereby corrective actions are implemented and followed through and communicated to staff. Residents meetings have been held monthly and residents and families have been surveyed in November 2014. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Improvement is required in relation to incidents whereby the registered nurse reviews all residents in a timely manner. Staff advised that there is a comprehensive orientation programme that provides new staff with relevant information for safe work practice; however, records of completed inductions could not be located. In-service education has been provided that exceeds eight hours annually and covers relevant aspects of care and support. Improvements are required whereby the caregiver training programme is re-established. Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. The prospective owner advised that rosters, staffing levels, and policies and procedures will remain in place following transition to new ownership.

Continuum of service delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. The medication management system includes policy and procedures that follows recognised standards. Resident medications are reviewed by the residents' general practitioner. A range of activities are available in the rest home and residents provide feedback on the programme. Glendale has food policies and procedures for food services and menu planning appropriate for this type of service. The service has a four weekly menu and dietitian input is obtained. Residents' food preferences are identified and this includes any particular dietary preferences or needs. Fridge and freezer temperatures are routinely monitored and recorded

Safe and appropriate environment

Glendale has a building warrant of fitness which expires on 20 December 2014. Part of the building was demolished in 2013 in preparation for redevelopment and addition of eight new residents' rooms; however this work was halted in September 2013. The prospective owner advised that building work will continue as soon as possible. Improvements are required in this area in relation to completion of building work, and ensuring laundry is not transported through the dining area. Further improvements are required around servicing and calibration of medical equipment, testing and tagging of electrical equipment and monitoring of hot water temperatures.

Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There is a lounge and dining area, and small seating areas throughout the facility. Furniture is appropriate to the setting and arranged that allows residents to mobilise.

There is a designated laundry which includes storage of cleaning and laundry chemicals. Chemicals are stored in a locked storage cupboard. The service has implemented policies and procedures for civil defence and other emergencies. A BBQ is available in the event of a power failure. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas. External garden areas are available with suitable pathways, seating and shade provided.

Restraint minimisation and safe practice

Glendale has restraint minimisation and safe practice policies and procedures in place. Staff has received training in restraint minimisation and challenging behaviour management. There were no residents with restraint or enablers on the day of audit.

Infection prevention and control

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. These reflect the needs of the service and are readily available for staff access. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the on-going 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	34	0	9	2	0	0
Criteria	0	80	0	10	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (five caregivers, one activities coordinator, one registered nurse, one nurse assistant and one temporary manager) confirm their familiarity with the Code. Interviews with six residents and four relatives confirm the services being provided are in line with the Code. Code of rights and advocacy training is provided as a regular in-service education and training topic. On interview the prospective owner is aware of the code of rights. The temporary manager has prepared an induction booklet for the prospective owner around consumer rights, advocacy, abuse and neglect, policies and procedures and the complaints process.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make	FA	Glendale has policies and procedures relating to informed consent and advanced directives. All five files reviewed included signed informed consent forms to allow for care and treatment, information sharing, taking of photographs, displaying the resident's name, collecting health

informed choices and give informed consent.		information and outings as part of the admission process and agreement. Resident files reviewed had completed resuscitation documentation. There were admissions agreements sighted which were signed by the resident or nominated representative. Discussion with four families identified that the service actively involves them in decisions that affect their relatives' lives
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	An advocacy policy and procedure includes how staff can assist residents and families to access advocacy services. Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available at reception. Residents' meetings include discussing previous meeting minutes and actions taken (if any) before addressing new items. D4.1e; The residents' files included information on residents family/whanau and chosen social networks. Residents are provided with a copy of the Code and Nationwide Health and Disability Advocacy services pamphlets on entry. D4.1d; Discussions with relatives identify that the service provides opportunities for the family/EPOA to be involved in decisions.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	The resident information pack informs visiting can occur at any reasonable time. Interviews with residents and relatives confirm that visiting can occur at any time. Family members were seen visiting on the day of the audit. Key people involved in the resident's life are documented in the care plans. D3.1.e Discussions with six residents and four relatives verify that they are supported and encouraged to remain involved in the community. Glendale staff support on-going access to community services (e.g. church, general practitioner visits, and library). Entertainers are invited to perform at the facility. D3.1h: Discussions with families verify that they are encouraged to be involved with the service and care.

Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Interviews with residents and relatives are familiar with the complaints procedure and state any concerns or issues are addressed. The complaints log/register includes the date of the incident, complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been no complaints logged in 2013 or 2014. Advised by the temporary manager that if a complaint is received then a full investigation would be conducted and resolutions obtained which included staff performance management as required. All communication with previous complainants had been documented for complaints. Resident meetings are an open forum for residents to air any concerns or issues which are then dealt with in a timely manner. D13.3h. A complaints procedure is provided to residents within the information pack at entry.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy information. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Interviews with six residents and four relatives identify they are well-informed about the code of rights. The temporary manager and registered nurse provided an open-door policy for concerns or complaints. Resident meetings (minutes sighted for November 2014) have been held providing the opportunity to raise concerns in a group setting. A resident satisfaction survey has been conducted by the temporary manager (November 2014). The survey includes questions relating to complaints process and residents rights, with respondents reporting they were overall satisfied or very satisfied. Advocacy pamphlets, which include contact details, are included in the information pack and are available at reception. The service has an

		advocacy policy that includes a definition of advocacy services, objectives and process/procedure/guidelines. D6, 2 and D16.1b.iii: The information pack provided to residents on entry includes how to make a complaint, a Code of rights pamphlet, and advocacy and Health and Disability Commissioner Information.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were able to describe the procedures for maintaining confidentiality of resident records. House rules and a code of conduct are signed by staff at commencement of employment. The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Church services are held weekly. Contact details of spiritual/religious advisors are available to staff. Residents and relatives interviewed confirm the service is respectful. A resident satisfaction survey conducted in November 2014 included questions relating to communication, complaints, care, privacy, respect, and dignity with very positive responses and comments conveyed. D4.1a: Residents' files included their cultural and /or spiritual values when identified by the resident and/or family. Residents and families are provided with an information pack which includes the home's philosophy of care. Discussions with residents confirm that they are able to choose to engage in activities and access community resources. Residents and family members confirm that they are given the right to make choices, for example, meal times and/or shower times. Five care plans reviewed identify specific individual likes and dislikes. The elder abuse and neglect policy includes definitions, signs and symptoms for detection, process for reporting, prevention and ensuring resident safety. Staff education and training on abuse and neglect was provided in September 2014. The temporary manager and registered nurse report there have been no identified incidents of abuse or neglect.

Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There is a Maori heath plan and an individual's values and beliefs policy which includes cultural safety and awareness. Discussions with staff confirm their understanding of the different cultural needs of residents and their whānau. There are no residents at Glendale who identify as Maori. There is information and websites provided within the Maori health plan to provide quick reference and links with local Maori. Interviews with caregivers, one registered nurse, and one temporary manager confirm they are aware of the need to respond appropriately to maintain cultural safety. Policies include guidelines about the importance of whānau. Cultural awareness training has been provided in December 2014. A3.2 There is a Maori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e).
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Care planning includes consideration of spiritual, psychological and social needs. Residents interviewed indicate that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives report that they feel they are consulted and kept informed. Family involvement is encouraged e.g. invitations to residents meetings and facility functions. D3.1g The service provides a culturally appropriate service by identifying the individual needs of residents during the admission and care planning process as reported by the registered nurse. D4.1c Five care plans reviewed include the residents' social, spiritual, cultural and recreational needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of house rules and a Glendale code of conduct. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on dignity and privacy and boundaries, evidenced in interview with the quality assurance coordinator and temporary manager. Interviews with

		caregivers, a nurse assistant, a registered nurse and the temporary manager acknowledge their understanding of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The quality programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and on-going in-service training. The recent resident satisfaction survey reflects high levels of satisfaction with the services that are received. The quality assurance coordinator has been responsible for coordinating the internal audit programme. Policies and procedures are provided by an external provider with regular updates. These are available in hard copy. There were staff meetings and residents meetings conducted. Residents and relatives interviewed spoke very positively about the care and support provided. Caregivers, a nurse assistant, a registered nurse, and an activities coordinator had a sound understanding of principles of aged care and state that they feel supported by the new temporary manager. A2.2: Services are provided at Glendale that adheres to the Heath & Disability Services Standards (2008). An implemented quality improvement programme includes performance monitoring (link #1.2.3). D1.3: All approved service standards are adhered to. D17.7c.There were implemented competencies for caregivers and registered nurse and these included medication administration, restraint use, fire safety, health and safety, and infection control. There were clear ethical and professional standards and boundaries within job descriptions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Policies were in place relating to open disclosure. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of incident reports reviewed, and associated resident files, evidenced recording of family notification. Relatives interviewed confirm they are notified of any changes in their family member's health status. The temporary manager and registered nurse can identify the processes

		that are in place to support family being kept informed. D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry. D16.1b.ii: The residents and family were informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The facility had an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) were provided with this information at the point of entry. Families were encouraged to visit. D11.3 The information pack was available in large print and was read to sight-impaired residents.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Glendale provides rest home care to 24 residents. The service is currently certified for 28 rest home and hospital level care beds (12 dual purpose beds), however, there were no hospital residents on the day of audit. A provisional audit was conducted and included an interview with the prospective owner of the land, buildings and business. The prospective owner intends to maintain the existing quality management system and externally provided policies and procedures. A transition plan has been developed and includes a new organisational chart, a business and quality and risk management plan and goals for 2015. The goals include the owner's intentions in relation to completion of the building project, reintroduction of benchmarking, maintaining the grounds and gardens, marketing, possible future hospital level care and staffing levels and skills mix. The previous owner was placed in receivership in November 2014. A temporary manager was appointed by the insolvency management company. The temporary manager is experienced in aged care management, having been a previous owner/manager from 2005–2011. The intention is that the temporary manager will become the permanent manager after the business has been signed over. The prospective owner intends to be part of the management team alongside the manager, quality coordinator and two business mentors with rest home ownership experience. The manager will report monthly to the management team on

		issues relating to occupancy, incidents and accidents, complaints, resources, financial matters and staffing. The temporary manager has been open with staff, residents and families to ensure that they have been kept informed of the developments. A letter to families was sent out in late November 2014 informing families of the impending sale. Staffing levels will remain unchanged until a review has been conducted. The owner intends to visit the facility every month and will be available to the manager by phone and email at other times.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	Currently, in the absence of the temporary manager, the registered nurse is in charge with support from senior care staff and the insolvency management company. The prospective owner would be available for support to the registered nurse following takeover of the business. The temporary manager is responsible for the day to day functions of the organisation, including oversight of the quality and risk management programme with support from the quality assurance coordinator. The manager works full time and the registered nurse works up to 30 hours per week. The temporary manager and nurse assistant cover the majority of the on-call component with the RN available for second on call. D19.1a; A review of the documentation, policies and procedures and from discussions with staff, identifies the service's operational management strategies, and quality and risk programme are in place to minimise the risk of unwanted events and enhance quality.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	The quality management manual includes the business quality risk and management plan and service philosophy. The quality programme is reviewed annually. The prospective owner has a business plan and a quality and risk management plan prepared for 2015. This quality and risk management plan has documented aims and objectives which are similar to the current plan for 2014 and include consumer focus, provision of effective programmes, meeting certification and contractual requirements, risk management, continuous improvement, service management and staffing, education, medication management, and food and fluids. Further goals specific for 2015 include reintroduction of benchmarking, completion of building work, falls prevention strategies, upkeep of grounds and

		gardens, building closer relationships with local schools and advertising and marketing. The current internal audit schedule and internal audits have been completed. Corrective actions have been developed where compliance is less than expected however, not all corrective actions evidence full completion. Staff meetings are held monthly. The previous agenda format included complaints/concerns, audits, training, risks and hazards, health and safety, infection control, incidents/accidents, restraint, quality activities, policies and procedures. This format was ceased being used in June 2014. Minutes are maintained however, there is a lack of evidence to support discussion of quality activities in the current meeting minute format. Management meetings have not been held in recent months. The temporary manager has conducted a resident survey in November 2014 with respondents advising that they are overall very satisfied with the care and service they receive. A survey evaluation has been conducted for follow up and corrective actions required. The service collects information on resident incidents and accidents as well as staff incidents/accidents. Benchmarking was previously conducted with an external benchmarking service. This has not been maintained in the past year. The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Fire drills and the fire evacuation scheme require improvements (link #1.4.7.1). There is an infection control manual, infection control programme and corresponding policies. There is a restraint use policy and health and safety policies and procedures. There is an annual staff training programme that is implemented that is based around policies and procedures. Records of staff attendance are maintained. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Documents no longer relevant to the service are removed and archived. D5.4 The service has policies/ procedures to support service delivery and these align with the client care plans. Policies are provided by an external provider who provides the service with regular updates. The quality

		assurance coordinator has been responsible for policy updates. The prospective owner intends to retain the current suite of policies and procedures. D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies. D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management D19.2g Falls prevention strategies include exercise programme, education for staff, residents and families, tagging resident walkers with a risk warning for staff and family, falls risk assessment, walking aids, physiotherapy assessment, use of appropriate footwear, correct seating, increased supervision and monitoring and sensor mats if required.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the quality coordinator and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff meetings including actions to minimise recurrence. Incident/accident forms are completed by either the registered nurse or the nurse assistant. Timely follow up by the registered nurse is not evident in the entire sample of resident incident forms reviewed for November 2014. Benchmarking with an external agency is not currently occurring. Discussions with the registered nurse and temporary manager confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Incident reports for November 2014 were reviewed and involved five residents. Incidents included falls, behaviour incidents and skin tears. One form was incomplete. Family notification was recorded on incident forms and in progress notes. D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.
Standard 1.2.7: Human Resource Management	PA Low	There are human resource management policies in place which includes

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		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 including the registered nurse and general practitioners is kept. The human resource policies also include orientation, staff training and development. Five staff files were reviewed and evidence that reference checks are completed before employment is offered. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Five caregivers were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. However, orientation checklists were not evident in staff files reviewed. Discussion with the temporary manager, quality coordinator, registered nurse and caregivers confirm that in-service training has been provided. It is noted that in the past 12 months the caregiver training programme (ACE) has not been provided to staff. There is an in-service calendar for 2014. The annual training programme exceeds eight hours annually. Four of five caregivers interviewed have not completed the aged care education programme. The registered nurse attends external training including sessions provided by the local DHB. Education relating to safe chemical handling and safe food handling has not been provided. Fire evacuation drill last conducted on 13 November 2014. Prior to this, a drill was last conducted in June 2013. Performance appraisals are overdue for 11 of the current staff employed.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low	The good employer policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home residents. There was at least one staff rostered on at any one time with one staff on-call. The nurse assistant and temporary manager provide first on call with the registered nurse providing second on call. Extra staff can be called on for increased resident requirements. There are three caregivers on duty on the morning shift, two on during the afternoon and one on duty overnight. The registered nurse works up to 30 hours per week on Monday, Wednesday and Friday. The nurse assistant works on Tuesdays and Thursdays. The temporary manager is employed full time. A cook is employed from Monday to Friday. Food is prepared for the weekend by the cook – which caregivers reheat, cook and serve to

		residents. The quality coordinator works 20 hours per week. The registered nurse was on leave for a four week period during July and August 2014. A replacement was not provided. During a more recent week of annual leave, the temporary manager replaced the registered nurse with a casual RN. Interviews with five caregivers, six residents and four family members identify that staffing is adequate to meet the needs of residents.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	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. An initial care plan is also developed in this time. Residents' files are protected from unauthorised access by being locked away in the nurses' station. Informed consent to display photographs is obtained from residents/family/whanau 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. D7.1: Entries are legible; however, not all entries are dated and signed by the relevant care giver or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the activities coordinator. Medication charts are in a separate folder.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	There is a policy for resident admissions that includes responsibilities, assessment processes and time frames. Needs assessments are required for entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and or family/whanau are provided with associated information such as the Code of consumer rights, complaints information, advocacy, and admission agreement. Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on

		entry to the service. Signed service agreements are signed for resident files sampled. The admission agreement reviewed aligns with a) -k) of the ARC contract and exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records. There was transfer information available in one of the files reviewed which was noted to be complete, appropriate, and fully documented communicated to support health care staff to meet the needs of the transferring resident
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID and allergies listed. Glendale uses four weekly blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. Medication charts record prescribed medications by residents' general practitioners; these are kept in the medication folders. The GP has recorded indications for use on six of ten PRN medication chart orders. Short life medications (eye drops and ointments) were dated upon opening in two of five eye medications. The medication folder includes a list of specimen signatures. Residents/relatives interviewed stated they are kept informed of any changes to medications. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. Education on medication management has occurred with competencies conducted for the registered nurse and senior caregivers with medication administration responsibilities. Signing sheets are in place for packed medication, short term, and prn medication. Ten medication charts reviewed identified that

		the GP had seen the resident three monthly and the medication chart was signed (with one exception link #1.3.3.3). Medications were safely stored on one medication trolley which is stored in the locked temporary treatment room area when not in use. All medications were up to date. Controlled drugs stored securely in a locked safe in a locked cupboard. The controlled drug register showed evidence of weekly and six monthly checks. The register showed evidence of two signatures when signing out controlled drugs except on night duty when there is only one staff member on duty who administers that medication and a stock take is undertaken every morning between the night and morning staff. One registered nurse was observed administering medications and followed correct procedure. One resident self-administers medications. These were observed to be stored in a locked container in the resident's rooms. Staff check each shift that the resident has safely self-administered medications and record this on the medication administration sheet.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Glendale has a fully equipped kitchen and all food is cooked on site. There is one cook who works Monday to Friday 0830-1330 and a tea shift person who works 1645-1915. D19.2: All kitchen staff have completed food safety training. The cook prepares casseroles and other meals for the weekends as per the menu and these are heated by the care staff. There is a four weekly rotating menu that has just been reviewed by a dietitian in November 2014. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes food safety policy, food services for the elderly, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served hot directly from the oven and oven top from food preparation containers to residents in the dining room or to their rooms as required. A tray service is provided at breakfast time to residents in their rooms if required. All food in the freezer and fridge is labelled and dated. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen as reported by the cook

		interviewed. Forms from the registered nurse to the kitchen were sighted for residents requiring special diets. The cook reports special diets being catered for include diabetic, soft and vegetarian diets. Weights are recorded routinely monthly as directed by the registered nurse. Residents report satisfaction with food choices, and meals are well presented. Relatives interviewed report that their relatives are very happy with the meals. There is homemade baking for morning and afternoon tea. Alternative meals are offered as required and individual resident likes and dislikes are noted on notice board in kitchen. There is a cleaning schedule, which is signed by member of staff completing cleaning tasks
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to residents is recorded and communicated to the resident/family/whanau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	An initial nursing assessment and initial care plan is completed within 24 hours of admission. The initial assessment includes: cognitive, sensory, mobility, breathing, hygiene and grooming, skin, continence, oral care, pain, safety and risk, dietary, social/values and beliefs, cultural and spiritual and sleeping. Personal needs, outcomes and goals of residents are identified. There is a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to); a) continence b) pressure area risk assessment, c) nutrition d) falls risk assessment e) pain assessment f) behaviour assessment and monitoring. The interRAI assessment tool is being commenced as the RN has undertaken InterRAI training. Assessments are conducted in an appropriate and private manner. All residents interviewed were satisfied with the support provided. Assessment process and the outcomes are communicated to staff at shift handovers, via progress notes, initial assessment and care plans. Resident and families advised that they are informed and involved in the assessment process this is evidenced in the progress notes. The assessment tools link to the individual care plans.

		The general practitioner completes a medical admission with two working days. Families and residents interviewed confirmed their involvement.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Residents' files include; resident information and family contact sheet, advanced directives and resuscitation status, the long term care plan, medical problem list and medical notes, activities social assessment, the diversional therapy plan, observations and weight charts, assessments, the initial assessment and care plan, short term care plans, needs assessments, lab forms, correspondence. The initial care plan is developed from the initial assessment and identifies the areas of concern or risk. Resident comprehensive long term care plans are individually developed with the resident and/or family/whānau who sign to acknowledge their approval of the care plan. Residents and family members interviewed stated they are involved in the care planning process. All resident comprehensive long term care plans reviewed were evidenced to be up to date. Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. The care plans are individualised for each resident need such as (but not limited to): Dressing/hygiene, skin integrity, mobility, sleep patterns, nutrition, continence, pain, orientation and perception and other clinical issues. Each aspect of the care plan includes goals, interventions and assistance required and evaluations. All care plans recorded sufficient detail to guide care staff. Activities care plans were completed for all files reviewed. There is evidence that residents are seen by the GP at least three monthly. The GP signs a form stating the resident is stable and for three monthly visits. Short term care plans examples sighted are cares required for infections (link finding # 1.3.3.3.).
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Glendale provides services for residents requiring rest home level of care. Individualized care plans are completed. The five caregivers, one nurse assistant and one registered nurse interviewed stated that they have all the equipment referred to in long and short term care plans necessary to provide care, including wheelchairs, walking frames, scales, transferring

		equipment, and a hoist. Clinical supplies are available with adequate supplies of wound care products, blood glucose monitoring equipment and other medical equipment. Weights are monitored monthly or more often if directed by the GP. There are currently no wounds being treated. Wound assessment and management plan was sighted in files sampled for previous wounds and there was evidence of input from the GP. Residents and family members interviewed confirm their current care and treatments they and their family members are receiving meet their needs. Continence products are available and continence products are identified for day use, night use, and other management. Specialist continence advice is available as needed. All falls are reported on the resident accident/incident form and reported to the registered nurse and manager. Falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral can be initiated as required. There is one registered nurse and one part time nurse assistant (former EN) who provide cover over each day of the week. A record of all health practitioners practicing certificates is kept. Needs are assessed using pre admission documentation; doctors notes, and the assessment tools which are completed by a registered nurse. Care plans are goal orientated and reviewed at six monthly intervals. During the tour of facility it was noted that all staff treated residents with respect and dignity, residents and families were able to confirm this observation
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is one qualified diversional therapist (DT) at Glendale who is responsible for the planning and delivery of the activities programme with assistance from the temporary manager and care staff. The DT works 1000-1530 Monday to Friday but this is flexible to allow for special events at weekends. The DT has worked at Glendale for 18 months and has also worked for many years in aged care at other facilities. Caregivers assist

		with activities during the week and at weekends. Activities are provided in the large communal lounge/dining room, in seating areas, gardens (when weather permits) and one on one input in resident's rooms when required. On the days of audit residents were observed being actively involved with a variety of activities including bocce, making Christmas decorations and one on one input. One on one activities this year have included movie outing, attending the Irish Rovers concert, and other off site entertainment individually with a staff member. The activities programme is developed monthly and a copy of the programme is available in the lounge, on noticeboards and in each resident room. The programme includes residents being involved within the community with social clubs, churches and schools. On or soon after admission, a social history is taken and information from this used to develop a diversional therapy plan which is then reviewed six monthly as part of the care plan review/evaluation. A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary. Glendale has its own van for transportation. Residents interviewed described weekly van outings, music entertainment and attendance at a variety of community events. The activities coordinator has a current first aid certificate. D16.5d Resident files reviewed identified that all include complete activity plans.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans were developed by the registered nurse on the day of admission and resident comprehensive long term care plans developed within three weeks of admission in care plans reviewed. Long term care plans are evaluated six monthly or if there is a change in health status. There was documented evidence that care plan evaluations were up to date in resident files sampled. Changes in health status trigger an update on the care plan. Care plan reviews are signed as completed by the RN. GP's review residents three monthly or when requested if issues arise or health status changes in four of five files sampled (link# 1.3.3.3). General

		practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The service carries out his instructions, giving him full confidence in the management of the residents. Short term care plans were evident for the care and treatment of infections (link #1.3.3.3).
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. The registered nurse interviewed confirms that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider.
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.	PA Low	There are policies in place for waste management, waste disposal for general waste and medical waste management. There an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. The laundry and sluice room are in different wings of the facility which are accessed through the dining area since the building work was stopped in September 2013. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interviews with caregivers described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed). Safe chemical handling training has not been provided in the past two years (link #1.2.7.5).
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Moderate	The service displays a current building warrant of fitness which expires on 20 December 2014. The assessment for hot water temperatures checks have not been conducted and recorded monthly since December 2013. Hot water is provided via an electric hot water system which is set at 45 degrees for resident areas. Medical equipment includes a hoist, chair

		scales, blood pressure machine and thermometer were sighted. The hoist has been serviced on 25 July 2014, however, the chair scales have not been calibrated by an authorised technician. The facility has a first floor area that can be accessed via either of two flights of stairs, one has a stair chair lift. In the upstairs area there are five resident rooms, a tea making area, DT office and storage. The internal courtyard area is part of the stalled building work. Two resident rooms, a small resident lounge, a medication room and two communal showers/toilets have been removed in the pre-build demolition. Two of the five upstairs rooms lie above the building area and are supported by temporary structures. On the ground floor there is a large communal lounge and dining area and a small sitting areas, another lounge is not available due to the halted renovations. There are sufficient communal toilets adjacent to the lounge and dining areas. There is a small seating area at the entrance available for residents and visitors. Residents were observed to safely mobilise throughout the facility. There is easy access to the outdoors. The exterior on the entrance side is well maintained with safe paving, outdoor shaded seating, lawn and gardens. Interviews with caregivers confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are five single rooms upstairs and 23 downstairs in Glendale. There are ten rooms with a shared full ensuite, two rooms with a shared ensuite toilet and one room with its own toilet, the other rooms share three communal bathrooms. The number of visitor and resident communal toilets provided is adequate. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/in-use

		signs.
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	The rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised.
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	There is a large lounge and dining room and small seating areas. The dining room is spacious, located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility and staff assist them if required. Residents advised that while the stalled building work has been less than ideal, there have been few interruptions to their daily life and routine.
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	Glendale has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection control education and there is appropriate protective clothing available. Care staff complete cleaning/laundry tasks. Manufacturer's data safety charts are available. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the room/facility.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	The service has a fire and emergency procedures manual. There is currently a trained person with a first aid certificate on each shift. First aid training was completed in November 2014 for all care staff. Fire safety training has been provided. A call bell light alerts staff to the area in which residents require assistance. The home is small and advised that most

		visitors are known to staff and/or management. Fire drill last conducted on the 13 November 2014. Prior to the, the previous drill was conducted on 17 June 2013. A civil defence kit is stocked and checked monthly. Water is stored - sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. Advised that a generator can be hired if required. Call bell system evident and in use in the resident areas. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. D19.6: There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Recommendation: Glendale retirement home has a NZFS approved fire evacuation scheme, dated 17 November 2006 and updated on 13 July 2011 following refurbishment. However, there has been changes to the floor plan in 2013 as part of the demolition and proposed building of eight new resident rooms. A building warrant of fitness was issued in December 2013. The service is encouraged to have the fire evacuation scheme reviewed to ensure that the changes to the layout (one corridor has been blocked off) are in keeping with a safe exit in the event of an evacuation. The fire evacuation scheme has not been reviewed since the change of the layout of the building in 2013.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed state the environment is warm and comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	PA Low	Glendale retirement home has an established infection control (IC) 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. The registered nurse is the designated infection control nurse with support from the temporary manager and quality coordinator (infection control team). The IC team meets to review infection control matters. Minutes are available for staff. Regular audits take place that include hand hygiene, infection

		control practices, laundry and cleaning. Annual education is provided for all staff. The infection control programme was last reviewed in May 2013.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The registered nurse at Glendale is the infection control nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control (IC) nurse maintains her practice by attending annual infection control updates. The IC nurse and IC team (comprising the management team and care staff) has good external support from the local laboratory infection control team and IC nurse consultant. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is all freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative 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.	FA	There is an infection control policy and procedures appropriate to for the size and complexity of the service. D 19.2a: 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 are developed by an external provider and reviewed and updated annually. The infection control policies include (but not limited to): hand hygiene; standard/transmission based precautions; prevention and management of staff infection; surveillance, antibiotic and antimicrobial agents; infectious outbreaks management; environmental infection control (cleaning, disinfecting and sterilising); single use items; construction/renovation risk assessment, personal protective equipment, medical waste and sharps and spills management.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the on-going education of staff and residents. This is facilitated by the infection control nurse with support from external provider who provides the service with current and best practice information. All infection control training is documented and a record of attendance is maintained. The IC nurse

		attends training annually - last session in May 2014. 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 are appropriate to their needs and this is documented in medical records. Education on hand hygiene and infection control provided for staff in February 2014, March 2014, and November 2014.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in Glendale's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at infection control meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the temporary manager.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint or enabler use on audit day. 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 was conducted in June 2014. Challenging behaviour management and de-escalation techniques training was provided in July 2014 and December 2014. A restraint audit was conducted in July 2014. The restraint approval group meets six monthly to review use of restraint or enablers. The registered nurse is the designated restraint coordinator.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality improvement activities are conducted including internal audits, feedback from residents and staff, staff and resident meetings, and surveys. The resident survey was conducted in November 2014 with positive feedback and comments from residents about the over care and services provided at Glendale. The quality coordinator has been responsible for managing the quality programme and conducting internal audits. The registered nurse has been delegated the clinical audits. On review of the internal audits and meetings minutes, the quality coordinator has developed corrective actions for those areas that evidence opportunities for improvements. Completion and sign off of corrective	a) Corrective actions have not been fully completed and signed off following internal audits; b) Results of internal audits and corrective actions are not evidenced to have been discussed with staff.	a) Ensure that corrective actions are completed and signed off; b) Provide evidence that staff are informed of outcomes of internal audit processes. 90 days

		actions has not always been conducted to show the improvements made. Meeting minutes reviewed for 2014 do not evidence that internal audit outcomes have been discussed with staff.		
Criterion 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.	PA Moderate	Staff report on a variety of incidents including medication errors, falls, skin tears, and behaviours. The quality coordinator collates the incidents and maps the times and places were incidents occur. A monthly summary is completed and this is report to staff via the staff meeting. A review of incident forms for November 2014 was conducted. These forms related to five residents. Staff record the incident in progress notes. One resident was not assessed post fall in a timely manner, one form was incomplete and one form was completed by the nurse assistant. The registered nurse did not view the resident.	a) Two of seven incident forms reviewed for November 2014 did not evidence that the registered nurse had assessed the resident post incident; and b) One incident report related to a resident who had had a fall. The resident was not reviewed by the RN until four days after the event.	a) And b) Ensure that residents who require clinical assessment post incident, are seen by a registered nurse and within appropriate time frames. 60 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	New staff are orientated to the service. Staff interviewed advised that new staff members are buddied with an experienced staff member. The service provides new staff with a comprehensive orientation package to complete. These forms were reviewed in the human resource folder. On review of five staff files,	On review of five staff files, there was no evidence to support that orientation packages have been completed by staff on commencement of employment. (ii) Staff appraisals are not up to date	Provide evidence that new staff complete the orientation packages. (ii) Ensure staff appraisals are up to date 90 days

		completed orientation packages were not available to view. Five caregivers interviewed stated that they feel that new staff are well orientated to their shifts and complete the orientation checklists. A recently employed caregiver advised that an orientation pack was completed and signed off.		
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.	PA Low	Education is provided to staff at staff meetings. Education conducted during 2014 includes abuse and neglect, first aid (all care staff) fire safety, medication management, resident's rights, hand hygiene, back care, falls prevention, infection control, pain management, restraint and enablers, privacy and confidentiality, challenging behaviours, cultural awareness, sexuality and intimacy, and continence. Safe chemical handling and safe food handling has not been provided in the past two years. The ACE training programme has previously been provided for caregivers. The temporary manager and caregivers advised that they have not progressed with the course due to the unavailability of an authorised assessor.	a) Safe chemical handling and safe food handling has not been provided in the past two years; b) The caregiver training programme (ACE) has not been provided in the past 12 months.	a) Provide evidence that safe chemical handling and safe food handling updates have been provided for staff; b) Provide evidence that the caregiver training programme has been recommenced. 90 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which	PA Low	A policy is in place which sets out the requirements for staffing levels and skill mix of employees. There are	The registered nurse was on leave for a four week period during July and August 2014 and replacement	Ensure that registered nursing cover is provided as per ARC contract

determines service provider levels and skill mixes in order to provide safe service delivery.		three caregivers on duty on the morning shift, two on during the afternoon and one on duty overnight. The registered nurse works up to 30 hours per week on Monday, Wednesday and Friday. The nurse assistant works on Tuesdays and Thursdays. The temporary manager is employed full time. A cook is employed from Monday to Friday. Food is prepared for the weekend by the cook – which caregivers reheat, cook and serve to residents. The quality coordinator works 20 hours per week. The registered nurse was on leave for a four week period during July and August 2014. A replacement was not provided. During a more recent week of annual leave, the temporary manager replaced the registered nurse with a casual RN.	RN cover was not provided. The nurse assistant worked full time during this period and the GP was available on call.	requirements. 90 days
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Five resident files and ten medication charts were reviewed. Medication charts are legible with the name of the GP recorded. Each entry is individually signed. Progress notes are written at least once a day by care staff. Care plans are handwritten and reviewed by the RN. Updates are made to the care plans as care needs change, however, not all entries in care plans have been signed and dated. Some care plans have been in place for a number of years with multiple entries and	a) Not all entries in care plans have been dated and signed; b) Due to the multiple entries and amendments made to care plans, it is unclear which entries are current. A number of care plans have been in place since 2011.	a) Ensure that all record entries are dated and signed by the staff member making the entry; b) Ensure that all documentation including care plans are legible and easy to follow. 90 days

		amendments. It is unclear which aspects are current due to the multiple entries.		
Criterion 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.	PA Low	The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management practice in accord with the guideline: 2011 Medicines Care Guides for Residential Aged Care. The service has in place policies and procedures for ensuring all medicine related recording and documentation is: a) legible, b) signed and dated, and c) meets acceptable good practice standards. All residents have individual medication charts with photo ID and allergies listed. Glendale uses four weekly blister packs; verification is completed by the RN against the drug chart on arrival from the pharmacy. Medication charts record prescribed medications by residents' general practitioners; these are kept in the medication folders. The GP has recorded indications for use on six of ten PRN medication chart orders. Short life medications (eye drops and ointments) were dated upon opening in two of five eye medications. The medication folder includes a list of specimen signatures.	a) Four of ten medication charts reviewed did not have indication for use documented on the PRN medication order; b) Three of five eye medications were not dated on opening.	a) Ensure that all (PRN) as required medications have indications for use documented by the GP on the medication chart; b) Ensure all short life medication is dated on opening. 60 days

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	Five resident files were reviewed for this audit. Long term cqre plans (LTCPs) are updated with associated assessments within timeframes. Wound management charts are utilised with timeframes set on assessment. Policy states the GP reviews residents at least three monthly. Four resident files evidence that a GP has seen the resident at three monthly intervals. Short term care plans are utilised for short term issues. Wound care documentation includes assessment, treatment plan, progress and evaluation.	a) One resident file did not evidence that the GP had reviewed the resident three monthly – time frame of five months; b) One wound care plan and one short term care plan (STCP) reviewed did not evidence that time frames were adhered to in respect of interventions and signing and dating when resolved.	A) All GP reviews to be undertaken at least three monthly; b) STCPs and wound management charts to be completed and evaluated within stated timeframes. 90 days
Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.	PA Low	The laundry and sluice room are in different wings of the facility with access through the dining area. Since the building work was stopped in September 2013, the layout of the facility has been altered. The end of one wing has been closed off so that staff are no longer able to walk right around the entire facility. They either walk through the dining room or exit the building and walk around the outside to access either the laundry or sluice room.	Staff are required to move through the dining room area with dirty and/or sluiced laundry to access the laundry or sluice room as corridor access between laundry and sluice was blocked off with building demolition and rebuild work in 2013.	Ensure that a safe and appropriate method of transporting soiled and sluiced linen is provided. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	Medical equipment includes a hoist, chair scales, blood pressure machine and thermometer were sighted. The hoist has been serviced on 25 July 2014. Calibration and testing of	(i). Chair scales have not been calibrated; (ii). Testing and tagging of electrical equipment is overdue; (iii). Hot water temperature monitoring has not been conducted	All electrical equipment must be tested and tagged, medical equipment calibrated and hot water testing recorded

		equipment is scheduled annually and hot water testing is scheduled monthly.	and/or records kept for the last 12 months.	monthly. 30 days
Criterion 1.4.2.4 The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.	PA Moderate	Two resident rooms upstairs sit above the stalled rebuild area underneath. These rooms, on the south side of the upstairs area, are supported by a horizontal beam, internal timber framing and five struts. The external surfaces are exposed to the elements with wiring and pipework exposed. The exterior cladding has been removed from part of the internal courtyard area which includes the exterior wall of the kitchen. A structural engineer visited the facility on the day of audit and assessed the area as safe for residents to reside above the unfinished building work. Other ground floor rooms, including the kitchen, have exterior cladding removed and are covered with building paper which is exposed to the elements. The halted building work within the internal area of the facility has caused disruption to the flow of the facility, and there are numerous areas which require completion. The internal building area where work has been halted is not accessible to staff, residents or visitors. The area has been secured with boarded up doorways and a key pad locked door. There are a number of small gaps and holes in wall surfaces. The prospective owner	(i). No external cladding on walls in front of the kitchen; (ii). Cracks and holes in door frames and walls resulting in exposure to the elements; (iii). Exposed internal structures and exposed wires since stalled building demolition and build from September 2013.	Provide evidence that the facility is structurally sound, and that building work is underway to ensure that residents and staff are not exposed to potential hazards. 90 days

		advised that building work is scheduled to recommence as soon as the transfer of ownership occurs.		
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Low	Emergency manuals are available for staff and training is provided in fire safety. New employees are orientated to the fire evacuation procedures and complete a fire safety quiz. A fire drill was last conducted in November 2014. Prior that this date, the last drill was conducted in June 2013. Staff have been trained in first aid.	A fire drill was conducted in November 2014. Prior to this, the previous drill was conducted in June 2013.	Provide evidence that fire drills are conducted six monthly as per requirements. 180 days
Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.	PA Low	The infection control programme includes infection audits, surveillance of infection data, education and training for new and existing staff. The programme was last reviewed in May 2013.	The infection control programme has not been reviewed in the past 18 months.	Provide evidence that the infection control programme is reviewed annually. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.