

Udian Holdings 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Udian Holdings Limited	
Premises audited:	Glencoe Resthome	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 14 January 2015	End date: 15 January 2015

Proposed changes to current services (if any):

The audit was undertaken as the rest home is in the process of being sold.

Total beds occupied across all premises included in the audit on the first day of the audit: 13

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

Glencoe Rest Home is located in Papatoetoe South Auckland. The facility contains 15 beds and provides rest home level care. There were 13 residents receiving care during this provisional audit.

There have been no significant changes to the facility or services since the last audit. An experienced registered nurse has returned to work at Glencoe Rest Home in August 2014. This audit was undertaken as the facility is in the process of being sold. The expected sale date is 20 February 2015.

At this audit there were five areas identified as requiring improvement. These are related to: ensuring all reported events are included in the monthly event analysis; staff education; ensuring documentation of short course medications meets requirements; and ensuring electrical safety testing and tagging and clinical equipment performance monitoring is undertaken. The prospective owner has yet to employ a registered nurse.

Consumer rights

Consumer rights and obligations meet legislative requirements. Staff discuss advocacy and the Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) with residents and their families on admission to the service. Information about the Code is easily accessed and displayed throughout the facility.

Residents have access to services which promoted independence. Involvement in decision making, respect and dignity is maintained. There are processes which ensured discrimination does not occur. Maori values and beliefs are acknowledged and cultural needs are effectively met by staff. Interpreter services are available and accessible. The service has a policy for open disclosure and effective communication between residents and families is promoted. The prospective provider has a good understanding of the Code, consumer rights and obligations to be adhered to.

Staff, residents and family members are aware of the complaints process. There is a high level of satisfaction expressed in relation to services provided.

Organisational management

The manager purchased Glencoe Rest Home in 1998 and continues to work in the rest home. The manager is responsible for ensuring the day to day needs of residents are met. The manager is supported by an experienced registered nurse. The mission, philosophy and goals of the rest home were documented and monitored.

The quality and risk programme provides the framework for the service and includes: complaints and compliments, incident and accident reporting, surveillance for residents with infections, audits, satisfaction surveys, policy/procedure review and risk and hazard identification and management. The results of quality and risk activities are discussed with staff regularly at monthly staff meetings or sooner during shift handover where applicable. Not all reported incidents were included in the monthly analysis and this requires improvement. Corrective action plans are developed where required, implemented and monitored for effectiveness.

Current accepted human resources processes are implemented. Staff have employment contracts and job descriptions. Staff performance appraisals are undertaken at least annually. Staff and contractors providing services have annual practising certificates where this is required.

An orientation programme is provided for all staff. No new caregiving staff have been employed since February 2011. The registered nurse recommenced employment at Glencoe in August 2014. Staff participate in regular on-going education. Not all topics have been included to meet the standards or provider's contract with Counties Manukau District Health Board (CMDHB). Staffing numbers and skill mix is appropriate.

Resident information was uniquely identifiable, accurate, up to date and accessible to staff when required. Resident information is securely stored and not accessible or observable to the public.

The prospective provider has owned another rest home in Auckland since October 2009. A new business manager will be recruited to assist with day to day management activities at Glencoe Rest Home. A registered nurse has yet to be recruited by the prospective owner and this is required prior to the purchase of the business. The current quality and risk programme will be continued with existing policies and procedures utilised. No significant changes are planned to the facility or services in the immediate future. Staff have been offered ongoing employment.

Continuum of service delivery

Services provided are clearly defined in the admission information book. The registered nurse met the contractual time frames for the development, review and evaluation of the care plans. Residents are reviewed by a general practitioner on admission to the service and at least three monthly, or more often, to respond to the changing needs of the resident.

A team approach to care is provided and continuity of care promoted. Referrals to other health and disability services are planned and co-ordinated as required. Transfers occur in a timely manner.

The activities programme is planned to effectively meet the recreational needs of the residents. Residents are encouraged to maintain independence and links with family/whanau and the community.

A safe medicine management system was observed. The registered nurse and senior caregivers are responsible for the medicine management. The service had documented evidence that staff were assessed as competent to perform the role. Medication records provided evidence that the required three monthly reviews had occurred by the general practitioner. Ensuring the documentation of discontinued short course medications is an area requiring improvement.

The residents' nutritional requirements are provided by the manager and staff. The menus were assessed by a dietitian as suited to the nutritional needs of the older person living in long term care. The service provides special diets, additional and modified diets that meet the needs of the residents. Food hygiene practices are met.

Safe and appropriate environment

Policies and procedures are available to guide staff in the safe disposal of waste and hazardous substances. Appropriate supplies of personal protective equipment are readily available for staff use.

The building has a current building warrant of fitness. Not all clinical equipment has a current calibration. Electrical safety checks of electrical appliances are overdue and these areas require improvement. The security arrangements and practices are appropriate.

There are 13 single occupancy bedrooms and two share twin bedrooms. All have hand washing facilities present. There is one full bathroom with a toilet and shower and three separate toilets for resident use. Call bells are present in the bedrooms and bathrooms. Personal space is sufficient for residents, including those who required staff assistance or the use of mobility devices. There is a separate lounge and dining area. There is good indoor/outdoor flow with deck and garden areas for the residents and their families to use. The facility has adequate heating and ventilation. There is no smoking on site.

Cleaning and laundry services are provided by employed staff. These services are monitored through the internal audit programme. Residents and family members interviewed confirmed the facility is kept clean and warm.

Emergency policies and procedures provided guidance for staff in the management of emergencies. Staff have current first aid certificates. There is an approved fire evacuation plan and fire evacuations drills are being conducted at least six monthly. There are sufficient supplies available on site for use in the event of emergency or an infection outbreak.

Restraint minimisation and safe practice

The service has a commitment to a `non-restraint policy and philosophy`. The restraint minimisation and safe practice policy complied with the standard. There was no restraint or enablers in use at the time of the audit. Staff interviewed had a good understanding that the use of enablers was a voluntary process along with approval and informed consent processes. Safety was promoted at all times for residents. Staff have access to education on managing challenging behaviour and safe and effective alternatives to restraint at orientation.

Infection prevention and control

There was a documented infection prevention and control programme. Implementation of this programme is facilitated by the registered nurse who is responsible for infection control activities. Infection prevention and control policies and procedures were available to staff and these are appropriate to the service.

Education on infection prevention and control activities was provided to staff during orientation and as part of the ongoing education programme. Relevant education was also regularly provided to residents and this was documented within the residents' records. Residents and staff were offered annual influenza vaccinations.

Surveillance for residents' infections was occurring. The surveillance was appropriate to an aged residential care service. Infection rates and trends were documented and recorded as part of the quality, risk management and health and safety programmes and communicated to appropriate staff and family members.

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	40	0	4	1	0	0
Criteria	0	88	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>The health and disability policy was reviewed and the policy notes that all employees are to be made aware of the Health and Disability Commissioner`s (HDC) Health and Disability Services Consumers` Rights Code (the Code), and attend mandatory education (including orientation). Staff are required to protect the confidentiality of residents, identify, acknowledge and eliminate barriers related to ethnicity and culture and maintain the privacy and dignity of residents.</p> <p>Staff interviewed were able to describe their responsibilities under the Code. Four senior caregivers (one of whom is the activities co-ordinator) confirmed that training on the Code begins during the orientation process. An in-service on this topic is scheduled to occur by the end of January 2015 (refer to 1.2.7.5). Residents` rights and obligations are incorporated into their everyday practice.</p> <p>Three of four residents interviewed (one was unable to speak clearly) confirmed they receive services that meet their needs and the obligations of the Code.</p>

<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>FA</p>	<p>The registered nurse interviewed reports that explanations are provided as required and residents are fully informed of the options or choices in respect to care and management. On admission to the rest home service, an informed consent to participate form is explained to the resident and their family/whānau representative. This document consents to residents participating in and having clinical records used in clinical teaching sessions, in research projects or for students to be involved in care/clinical service delivery.</p> <p>Informed consent is also obtained for transportation in the rest home vehicles for purposes of activities outings and/or attending appointments. Photographic consent is obtained for the photographs utilised on the medication records and clinical files.</p> <p>Any advanced directives are acknowledged and retained in the individual resident`s records reviewed. These are reviewed six monthly when the multi-disciplinary reviews are performed.</p> <p>Procedures and practice discussed, observed and documented are in line with the policy on consent reviewed. The policy is consistent with current best practice.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Policy documented identified the residents` rights to access an independent advocate and their right to have a support person of their choice.</p> <p>Staff interviewed verified education and training relating to the Code and to access advocacy services. A list of advocates is available with contact details. Pamphlets related to the Health and Disability Commissioner Advocacy Service are available. Residents are able to have a support person of their choice.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Visitors are welcome to visit at any time. Family interviewed verified that they could visit any time. The activities co-ordinator explained that activities in the community are encouraged. Families are able to take residents on visits home with family or for an outing. The residents interviewed confirmed they have access to visitors of their choice. Support services are available in the community. The diversional therapist interviewed states she endeavours</p>

		to take the residents out for outings in the community.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy details the residents or family member's right to make a complaint. The process for reporting, investigating, documenting and following up the complaint is documented and the timeframes align with the requirements of the Code.</p> <p>The manager and the registered nurse (RN)/quality facilitator advised there have been no complaints received from the Health and Disability Commissioner (HDC), District Health Board (DHB) or Ministry of Health (MOH) since the last audit. A complaints register is maintained. Very few complaints have been received and these have been investigated and responded to in a timely manner.</p> <p>All residents and family members interviewed confirmed being aware of the complaints process and having no complaints. The staff and managers interviewed were able to detail their responsibilities in the event a resident made a complaint.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Opportunities for discussion regarding the Code are included as part of the booking process with information provided. Information about the Code is available in different formats and displayed throughout the facility. Pamphlets are available in the main office. The residents interviewed were able to provide insight into the Code.</p> <p>The Nationwide Health and Advocacy Services information is included in the service information folder. The Nationwide Advocacy Service contact details are printed on the reverse of the Code. Pamphlets are available and sighted. The pamphlets are accessible to staff and residents at all times.</p> <p>The prospective provider interviewed has a good understanding of the obligations and responsibilities in relation to consumer rights that have to be adhered to.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in</p>	FA	<p>Policy reviewed includes the requirements for staff to maintain and protect the confidentiality of all patients. The Abuse Policy reviewed notes all types of abuse and reporting processes for staff to follow. Education was provided</p>

<p>a manner that has regard for their dignity, privacy, and independence.</p>		<p>on the 3 April 2013 and nine staff attended. Staff interviewed had a good understanding of abuse and neglect.</p> <p>All residents and their family/whanau have access to services that promote independence, involvement in decision making, respect and confidence whilst receiving care.</p> <p>Cultural, religious and social needs are identified during the initial assessment process. Where there are identified needs, these are carried over to the initial care plan. Values and beliefs are acknowledged by staff. Information regarding religious groups/resources which include church services in the community and church visitors and contacts are available on the contact index sighted.</p> <p>Preferred names of residents are ascertained on admission to the service. These are documented on the respective files if applicable.</p> <p>Residents are fully supported by family/whanau with the resident's consent. Residents have their own rooms and their own belongings of their choice. Privacy is maintained at all times.</p> <p>Information on services available in the community for additional support is discussed with the activities co-ordinator for the service. The activities co-ordinator interviewed stated that often appointments for residents, such as to a general practitioner appointment, are met in the community. These are also acknowledged as an outing for the resident, so as to encourage the resident's independence.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is a Maori Health Plan which had been reviewed annually. The service is committed to the principles of Te Tiriti o Waitangi and works in partnership with Ngati Otara Marae. Input from the Maori Health Advisor and contact details were acknowledged. The Maori Health Plan has a clearly documented scope and direction and purpose documented.</p> <p>The te whare tapa wha model considers the four cornerstones of Maori well-being which had to be in balance for each individual to be healthy and at peace. The plan has been developed with a holistic approach to care delivery. Examples of how this would be effectively met were provided.</p> <p>Glencoe Rest Home provides aged care residential care services which</p>

		<p>respect and acknowledge the needs of Maori and the cultural needs of all other residents. Currently there is one resident who identifies as Maori. Providing culturally appropriate services is seen as supporting a healthy environment. This was verified by the one Maori resident interviewed and family/whanau interviewed. Code information is available in Te Reo Maori.</p> <p>The Maori Health Advisor a Kaumatua from the Marae is available to bless residents' rooms as required. Rooms are blessed if Maori residents request this, prior to admission or alternatively if a resident died unexpectedly the room would be blessed prior to being occupied. Tikanga recommended best practice policy was reviewed. The manager, the diversional therapist and the registered nurse have attended tikanga best practice training (16 hours) on the 7 March 2013. The identification of cultural implications on care and requests from whanau are acknowledged when developing the individual care plans for residents.</p> <p>Staff interviewed acknowledged special considerations for Maori residents, such as not rushing a resident to make a decision, and 'boil ups' meal requests were met. Requests from whanau were also considered and a spokesperson for the resident is established on admission to the service.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents receive serviced that respect their cultural identity to their satisfaction and do not discriminate against them in any way. Residents from ethnic origins are specifically asked to verify any special cultural requirements at the time of admission to the service. It was observed that there were residents from a number of different cultural groups, such as Dutch, Maori, Pacific Islanders and European residents, who when interviewed, reported their cultural needs were effectively met.</p> <p>Residents' records sighted confirmed the identification of ethnicity and specific cultural needs. Individual care plans reviewed reflect residents' cultural needs were effectively met. Staff ethnicity was recognised with staff from Fiji, Fijian Indians, Indians, Pacific Island and European.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	FA	<p>The health and disability policy includes details that staff are not to discriminate, coerce, harass or exploit residents but rather are to act as an advocate for the resident and provide information on how independent</p>

<p>harassment, sexual, financial, or other exploitation.</p>		<p>advocacy services can be accessed if required. Employees are to ensure patients had a support person if the resident consented.</p> <p>The health and safety workplace bullying policy details how allegations of bullying would be reported, investigated and managed.</p> <p>Discrimination is not tolerated. The manager and the registered nurse reported there were no incidences of bullying reported as there are adequate processes in place to ensure discrimination did not occur.</p> <p>Professional boundaries for the registered nurse are clearly defined as a requirement for the New Zealand Nursing Council. The one registered nurse has attended the mandatory workshop training on the 9 April 2013 on 'Professional boundaries and Code of Conduct' to meet their annual practising obligations.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The manager and one registered nurse and four senior caregivers interviewed are focused on evidenced practice, research and training. A handover was observed between the morning and afternoon shift staff. This was managed efficiently by the staff concerned. A hand-over record sheet was provided at the time with important changes being updated to keep all staff informed. Staff retention is especially well managed with the average length of stay in employment being seven to ten years. Feed-back surveys from residents and family/whanau are used appropriately and provided an opportunity to focus on any recommendations and/or if failures were observed.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The communication policy was reviewed. The use of a family communication page in the records reviewed evidences good communication with family/whanau.</p> <p>There is an interpreter service policy which has been reviewed. Interpreter services are available from Counties Manukau District Health Board (CMDHB). Use of the CMDHB approved interpreter servicers is at no cost to the resident. The open disclosure policy is available and a flow chart documented to guide staff. The open disclosure policy clearly defines and refers to the HDC article available on the website on open disclosure policy.</p>

		<p>An environment to ensure effective communication is provided. Residents interviewed report that family/whanau are encouraged to be involved with the resident.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Glencoe Rest Home has a documented mission statement and philosophy on care that is focused around the provision of individualised, resident focused care that maximised resident independence within a homely environment. The manager monitors the progress in achieving these goals via the internal audit process and review of resident satisfaction. The manager has an open door invitation and residents and family are able to contact the manager at any time.</p> <p>The organisation chart is documented within policy. The day to day operations and ensuring the wellbeing of residents is the responsibility of the manager. The manager and spouse have owned Glencoe Rest Home since 1998. Prior to owning Glencoe Rest Home the manager worked as a caregiver in the rest home. The manager currently lives on site. Both owners work at Glencoe Rest Home (Glencoe). The owner and current manager have participated in more than eight hours of education relevant to managing an aged care service as required to meet the contract.</p> <p>A RN recommenced employment at Glencoe in August 2014 and is reported to work at Glencoe on average 16 hours a week. The RN has worked for Glencoe in the past. The contract requirements are met for the current owner.</p> <p>The prospective owner has owned another rest home facility in Auckland since October 2009, and prior to this worked for a multi-national company for ten years in a variety of roles, including as an accounting and systems support officer. The prospective manager has worked in the other rest home on a day to day basis with the management responsibilities shared with a registered nurse.</p> <p>The prospective owner has developed a new organisation chart detailing how the services will be managed. The prospective owner's plan is to work between the two rest homes on a daily basis. The prospective owner will be responsible for ensuring the day to day care needs of the residents are met at Glencoe Rest Home. A business manager (who is new to health) has been recruited to assist the prospective owner with management of the</p>

		<p>facility. The business manager will live on site. The prospective business owner curriculum vitae details an employment history that includes staff recruitment, training, management, customer service and computer/information technology technical skills while working abroad. The prospective business manager has already completed a food safety training (certificate sighted) and is booked for first aid training. The philosophy of the prospective owner is to continue to maintain a home like environment that maximise the quality of life of residents.</p> <p>A transition plan has been developed by the prospective owner. The intended and proposed handover date is stated to be 20 February 2015. A one month handover time/orientation to the new owner is planned. The prospective owner has already had the facility building reviewed to ensure building requirements are met and liaised with other suppliers in relation to the provision of insurance, fire and security services, communications systems/services, payroll and accounting services. A meeting is also reported to have been held with the applicable contract holder at Counties Manukau District Health Board (CMDHB). Glencoe staff have already been informed of the proposed sale of the business and offered ongoing employment. This is verified during staff interview. The timeframe for communicating with the residents and family members has been identified. The prospective owner has yet to employ a registered nurse. All CMDHB contractual requirements (ARRC) related to the provision of the registered nurse activities has yet to be finalised by the prospective owner. Refer to criterion 1.2.8.1.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The diversional therapist (DT) is also a caregiver and assists the manager to ensure day to day care needs of residents are met. The DT was employed in February 2011. The diversional therapists has completed an industry approved qualification in aged related care and is in the process of completing a qualification related to diversional therapy. The DT reported being able to arrange staffing and purchase supplies as necessary and was able to detail responsibilities in the manager's absence. The manager (or the manager's spouse) is reported to be normally available by phone and undertakes financial management activities including processing payroll and paying accounts via the internet.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a documented quality and risk plan. This details how quality and risk are being monitored and included all required components to meet the standards.</p> <p>Policies and procedures are available to guide staff practice. One copy of all policy manuals is available on site. These have been signed as reviewed by the manager in June 2014. Policies are required to be reviewed every two years and document control was the manager's responsibility.</p> <p>Internal audits are undertaken. A schedule has been developed detailing when the audits are to be undertaken. The majority of randomly selected audits scheduled for 2014 have been completed using template forms. This includes audits related to housekeeping, the environment, laundry services, documentation, food services and aspects of care. The audit reports confirm there was overall good compliance by staff in meeting the requirements of policy and audit criteria. The results were communicated to staff at staff meetings. The results are also linked to applicable annual reviews that have been completed.</p> <p>Patient satisfaction surveys were last completed in November 2014. A separate food satisfaction survey was also completed in 2014. Overall there is a high level of satisfaction reported by the residents who completed these surveys. Where areas for improvement have been identified as the result of an audit, resident feedback, accident or incident, corrective action plans have been developed, implemented and monitored for effectiveness in the sampled records. Periodic resident meetings have been held. The most recent was in June 2014. The manager reports that having an open door policy has been a more effective way to keep open communication channels with residents and families rather than via meetings. This was verified by the residents and families interviewed.</p> <p>Staff meetings are held monthly. The minutes of the last four meetings were reviewed and included information on audit results, incidents and accidents, number and type of resident infections, human resource issues, facility routine, policy/processes, staff training/education and other issues relevant to the service.</p> <p>Staff are required to report any hazards. The most recent hazard was reported on the 5 January 2015. Where hazards have been identified these</p>

		<p>have been eliminated or minimised. A hazard register was available that detailed a range of hazards related to the facility/environment as well as resident care and the mitigation strategies.</p> <p>A risk management plan is in place. Organisation risks are categorised and documented and mitigation strategies noted.</p> <p>The contractual requirements are met by the current owners.</p> <p>The prospective owner was interviewed and stated the existing quality framework will be implemented including the use of all existing policies, incident reporting framework and infection surveillance processes. The prospective owner has reviewed the Glencoe quality and risk plan during audit and subsequently has made some minor amendments to the plan following the onsite audit. As there is minimal turnover of caregiving staff at Glencoe (refer to 1.2.8.1) the prospective owner has stated the existing policies and procedures will be utilised to assist with continuity of care and process during and after the sale of the rest home. The prospective owner advises over time the quality and risk activities and policies and procedures will be reviewed with the option of aligning some practices and documentation and the quality and risk documents/processes used by the prospective owner in the other rest home owned.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>There is an incident and accident reporting process sighted and implemented by staff. Applicable events are being reported in a timely manner and disclosed to the resident and or designated next of kin. The number and themes of incidents and accidents are discussed and reported at the regular staff meetings. Not all reported events are included in the monthly analysis data.</p> <p>The manager and the RN/quality facilitator were able to detail the type of events that were required to be reported as an essential notification. There have been no events requiring this level of reporting since the last audit.</p> <p>The current manager and the prospective owner were both interviewed. Neither were aware of any legislative or compliance issues that will impact on the provision of services.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There has been a low turnover of staff at Glencoe with the most recent employee recruited in February 2011. Whilst references checked were noted to have been completed the records were not available for review. This has not been noted as an area requiring improvement as the employee was employed prior to the last full certification audit. The RN and the manager advised that recruitment processes have changed over time and reference checks would now be retained. A police check also commenced at the same time.</p> <p>The registered nurse returned to Glencoe in August 2014. This RN has worked in Glencoe Rest Home in the past and returned when the previous RN was unable to complete rostered hours.</p> <p>Current annual practising certificates (APCs) were sighted for both RNs, the general practitioners (GPs), podiatrists, and pharmacists. A current APC for the dietitian is not on file. However, the RN and manager advise the dietitian has not provided services since the APC on file expired. A copy of the dietitian's current APC was requested by the manager and RN during audit.</p> <p>The five staff files reviewed have records verifying staff have completed an orientation programme that is relevant to the service setting and suitably prepared staff for their roles and responsibilities. Orientating staff are supernumerary and 'buddied' by a senior staff member for a number of shifts until the staff member is deemed able to work independently. Performance appraisals have been completed within the last 12 months for the staff whose files were reviewed. Employment contract and job descriptions were in staff files sampled.</p> <p>Staff are able to participate in relevant ongoing education and records of attendance are maintained. Not all topics required to meet the standards and contractual (ARRC) requirements have been provided in the last two years.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>PA Moderate</p>	<p>A policy detailed staffing requirements and this meets the ARRC contract requirements. There is at least one caregiver on duty at all times. The registered nurse works approximately 16 hours a week and this includes some quality and risk activities. The RN role will become vacant at the end of January 2015. Residents and family members interviewed advise the</p>

		<p>residents receive timely and appropriate care from all staff.</p> <p>All current staff have been offered employment by the prospective manager as confirmed during interview with the current manager, prospective manager and staff. The prospective manager was aware of the ARRC contract requirements for staff and this includes skill mix. A registered nurse has yet to be recruited by the prospective owner.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Resident information is stored securely and is not on public display. The residents' names are recorded on the residents' register with all relevant information required. National Health Index Numbers (NHIs) are recorded as the unique identifier number for each individual resident. The nursing records are current and accessible. Resident records reviewed (four individual residents' records randomly selected) are integrated. Admission data includes next of kin and all contact details for each resident.</p> <p>Progress notes are documented each shift. A written handover sheet is utilised for this purpose. Records sighted were signed and dated appropriately. Clinical discharge documentation was entered into the resident register appropriately. Transfers, discharge and deaths are recorded. The family communication records are maintained for each resident.</p> <p>Records are archived when appropriate but able to be retrieved as required.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The entry and exit to the service policy details the obligations of the service provider when admitting residents to the facility. There is an enquiry book which is maintained and all details obtained are validated prior to acceptance of a resident. All residents are required to have a needs assessment by the district health board (CMDHB) needs assessment and co-ordination service (NASC) to ascertain the care level required. Only rest home level residents can be admitted to the facility. The manager and the registered nurse (RN) interviewed understood the entry criteria obligations.</p> <p>The facility is staffed 24 hours a day seven days a week (24/7). The RN interviewed states that the manager is on call after hours and the GP is always available. The senior care staff interviewed are experienced and</p>

		<p>received full orientation at commencement of employment. The registered nurse is responsible for the initial assessments and initial care plan development for all residents on admission to the service. This responsibility is on-going with reviews at least six monthly or as required.</p> <p>There was one registered nurse. The RN had not completed the interRAI training. A new registered nurse has yet to be employed for when the prospective owners take over the business (refer 1.2.8.1).</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Depending on the circumstances for transfer, transportation would be arranged by the staff. In an emergency situation the GP arranged with CMDHB admitting office and when accepted family would be notified and a referral letter documented. Ambulance transfer was mostly used to the CMDHB. A copy would be retained on the resident's individual record. There is a 'DHB hot line' that the GPs or RN can ring for advise at any time. The 'yellow envelope system' is used for this service if a resident transferred to the CMDHB hospital. The cardiopulmonary resuscitation (CPR) status for the resident was included.</p> <p>A formal discharge process is utilised and the resident was discharged appropriately. The resident register is updated, if the details had changed significantly. Safety is promoted at all times during transition, exit, discharge or transfer.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>A safe medicines system is in place and was observed during the lunchtime medication round. The senior caregiver understood the responsibilities and safe practice was observed. Medication policies are available to guide staff. All staff had completed medication competencies and this was verified by the education records provided. The medicines and the medication trolley were securely stored when not in use.</p> <p>Eight medication records were reviewed. Signing sheets were dated, signed off and signatures verified with the specimen signature list sighted. Allergies and sensitivities were recorded to alert staff as needed. Medication blister packs are checked when they are dispensed to the facility and before administration.</p>

		<p>The GP interviewed ensured the three monthly medication reviews occurred. There was one action required in relation to short term medications which have been completed but had not been signed off by the GP. There were no residents self-medicating. Policy was documented to guide staff should this be required. The standing orders were signed off by the general practitioners, as applicable, annually.</p> <p>The controlled drugs were stored appropriately, checked weekly and balances were correct and able to be verified. Any medications not in use are returned to the pharmacy.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Policies and procedures were sighted that included food safety and all kitchen services. The manager is responsible for the food service. Staff prepare the meals daily. Night staff do baking for each day. The manager and day staff prepare the main meal for midday and the evening meal. The manager buys all food fresh on a daily basis. Food was stored effectively and safely. Kitchen cleaning duty schedules were documented for staff to follow. Fridge/freezer temperatures were monitored daily. All equipment and resources were readily available, inclusive of personal protective items, such as gloves, aprons, and hats.</p> <p>The registered nurse ascertains any dietary needs of the residents on admission. A copy of the assessment profile was provided to the kitchen staff. Special diets were met. Modified foods and textures were monitored by the manager and the RN.</p> <p>There was a small dining room which was in close proximity to the kitchen. The caregivers were observed assisting the residents in the dining room as required.</p> <p>Evidence was sighted of menu planning and menu review by a dietitian (four years ago), cleaning schedules and the kitchen audits that had been completed. The menu plans rotate four weekly. Satisfaction surveys were performed annually and residents and family interviewed reported satisfaction with the food services provided.</p>
Standard 1.3.2: Declining Referral/Entry To Services	FA	The service is available to rest home level residents. Should a resident

<p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>require higher level of care, for example hospital level or secure dementia care, a re-assessment is initiated by the general practitioner. The registered nurse interviewed stated that assistance would be provided to access other services if and when needed. If the resident was declined from receiving services this would be recorded in the enquiry book and on the resident register.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The assessment process was documented and the responsibilities of assessing the progress of residents was demonstrated by the registered nurse interviewed. One resident's family confirmed at interview that an assessment had occurred. Care is provided daily and any findings are recorded in the individual resident's record sighted. The manager and/or registered nurse interviewed communicate relevant information to the family/whanau by phone or when they visited. If any variations occurred contact with the family would be made at the time. Four resident records were reviewed. The residents interviewed expressed that their wishes were considered and choices were provided during all stages of service delivery. The care plans reviewed verified interventions were changed to meet goals set.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The four residents' records reviewed evidenced that they were integrated and accessible. The required interventions to achieve the aims were documented in the care plan. The progress records were documented and completed in a timely manner by the senior caregivers or the registered nurse.</p> <p>The staff were observed providing handover to the oncoming staff. The care plans reviewed were individualised, reflected current needs and were accurate. Continuity of care was provided and encouraged. Residents and family interviewed expressed high satisfaction for the care and support provided. All thirteen residents' care plans had recently been reviewed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in</p>	<p>FA</p>	<p>Residents' needs were identified on admission and throughout each stage of service delivery. The initial care plan is developed on admission and the</p>

<p>order to meet their assessed needs and desired outcomes.</p>		<p>long term care plan is developed within three weeks of admission. The NASC assessment is always considered when developing the initial care plan. Resident focused outcomes and interventions are documented.</p> <p>Interventions were clear and focused on achieving the outcomes. Community services are utilised to support the needs of the resident, for example, the infection control nurse specialist at CMDHB, should advise be required regarding an infection control issue. One general practitioner provided services to the majority of residents. Three other GPs provided services for individual residents. Staff confirmed the GPs are available for advice when applicable.</p> <p>Residents and family interviewed reported care provided was appreciated and advice provided by staff was consistent and relevant.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme was documented monthly but displayed weekly. The programme was varied and interesting. The activities co-ordinator maintained records of resident participation and acknowledged that attendance was voluntary. The activities co-ordinator has been in the role for four years and is studying towards the Careerforce diversional therapist qualification.</p> <p>Activities assessments are performed on admission and the information gained was used when developing and implementing the individual activities plans to meet the needs of the individual resident. The plans sighted were reviewed six monthly at the same time the care plans were reviewed.</p> <p>Residents and families interviewed reported the activities were enjoyed by the residents and the family can participate whenever they wish.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurse reviewed the care plans six monthly or more often if required. Evaluations were resident focused and indicated the degree of achievement or response to the support/interventions in place towards meeting the desired outcomes. The RN interviewed discussed the reviews with the GP if the residents' health status or needs had changed.</p> <p>The care plans reviewed evidenced changes were acknowledged and the care plans updated accordingly. Family were notified. Short term care plans</p>

		<p>are available and sighted as being utilised. These processes were documented in the medical and nursing assessments and the resident's individual progress records reviewed.</p> <p>The multi-disciplinary team reviews are organised by the RN. The four residents and four families interviewed confirmed their input into the MDT meeting.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referrals are arranged by the general practitioner as required and were facilitated in a timely manner. Outpatient referral letters and acceptance appointments were verified in the four individual resident's records reviewed. Copies of referrals were maintained in the records. The families are notified and are able to attend the outpatient appointment if they wish to do so. The activities co-ordinator when possible takes residents to appointments.</p> <p>Re-assessments can be arranged when required by the GP concerned. If the manager felt a resident no longer met the requirements to stay in the rest home service but required higher level of care this would be arranged. The family/whanau would be notified.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies were sighted to detail how waste was to be segregated and disposed. The policy content aligned with current accepted practice.</p> <p>Chemicals sighted were stored in designated and secure areas. Material safety data sheets and a reference wall charts on actions to take in the event of exposure were sighted for chemicals in use.</p> <p>Appropriate personal protective equipment (PPE) was available on site including disposable gloves, aprons, masks, and face protection. The staff interviewed on this topic detailed what PPE was required to be worn by staff and when in order to minimise risk of exposure to blood and other body fluids and contaminated items/equipment.</p> <p>Staff advised they would report inadvertent exposures to hazardous substances and blood and body fluids via the incident reporting system.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>There was a current building warrant of fitness. An external company undertakes performance monitoring and electrical safety checking of clinical equipment. Electrical equipment was overdue for electrical testing and tag checks. Maintenance requests are documented in a booklet and requested tasks signed as being completed.</p> <p>Grab rails were present in the patient shower and toilet areas. There were handrails in the corridors.</p> <p>The bathroom floors had non slip linoleum floor covering. Furniture and fixtures were appropriate to the service setting. Residents have personalised their rooms.</p> <p>The residents' bedrooms are of a suitable size. The residents and family members interviewed confirmed the facility is appropriately furnished to create a home like environment.</p> <p>There was a number of external chairs that residents and family can utilise including on the deck and under the shade of trees.</p> <p>The prospective owner was interviewed and stated there were no immediate plans to make any significant changes to the facility/environment. Some changes were discussed that are being considered for approximately 12 months following purchase and these related to the house adjacent to the rest home.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Hand basins were present in each resident's bedroom. Waterless hand gel was also available for staff.</p> <p>There was one bathroom with a shower and toilet and three separate residents' toilets. The two caregivers advised there were enough bathroom and shower facilities for the residents' use. Privacy locks were installed on bathroom doors. There was a separate bathroom for the use of staff.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and</p>	<p>FA</p>	<p>There are 13 single occupancy rooms and two double occupancy rooms. The rooms contained sufficient space for the residents, personal possessions and use of mobility devices if required. Residents were sighted mobilising independently inside and outside the rest home independently,</p>

<p>setting.</p>		<p>including while using a mobility aid.</p> <p>The staff interviewed advised there was sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There was a lounge and separate dining area that residents and their family or visitors can use. There is a separate alcove at the end of one of the corridors where the residents' telephone was located along with some soft furniture. There was also a shaded furnished area on the veranda. The residents and family members interviewed confirmed that there was sufficient space available for consumers and support persons to use in addition to the residents' bedrooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Policies detailed how the cleaning and laundry services are to be provided. The caregivers share these duties over a 24 hour period. The residents and family members interviewed confirmed the rest home is normally kept clean and tidy and residents' laundry is washed and returned in a timely manner. This was also noted in the resident satisfaction survey (last undertaken in November 2014). Audits of cleaning and laundry services were undertaken regularly and reports demonstrated a high level of compliance with the rest home policy and service requirements and prompt remedial action where improvements were identified.</p> <p>Chemicals were stored in designated secure cupboards. Instructions for managing emergency exposures to chemicals was readily available to staff.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The fire evacuation plan has been approved by the New Zealand Fire Service (NZFS) in a letter dated 8 May 1999. A fire evacuation drill was being conducted six monthly. The last drill occurred on 24 November 2014 and the records were sighted.</p> <p>Policy documents and a wall mounted emergency "flip chart" included guidance for staff on responding to other events, including (but not limited to) earthquake, flooding and volcanic eruptions.</p>

		<p>A review of the staff files and training records verifies all staff had a current first aid certificate. The caregivers interviewed detailed their responsibilities in the event of emergency.</p> <p>There were sufficient supplies available of dry food, drinking water, lighting, blankets and other clinical supplies for use in emergency. A sufficient store of dry food stuffs was also available.</p> <p>Call bells were present in the bathrooms and residents' bedrooms. They alert audibly and a light also illuminates outside the room. Three call bells tested at random were fully functioning.</p> <p>The caregivers interviewed advised the external doors and windows were checked and locked prior to darkness. The gate at the entrance to the facility has a pin code and residents and family members are provided with the code. Other visitors or contractors presenting use an intercom to call for staff.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There were windows present in all residents' bedrooms. Doors and windows were sighted open during the audit. Heating is provided when required from two wall mounted heat pumps in the corridor areas. There were also wall mounted heaters present in each resident's bedroom.</p> <p>The residents and family members interviewed confirmed the facility was always warm and well ventilated. There were currently no residents who smoke. Staff and visitors are required to smoke off site.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>There was an infection control programme dated as being reviewed in June 2014 by the manager. This plan details the four main components of the infection prevention and control programme. The responsibilities for implementing the programme were detailed and are shared by all staff.</p> <p>The registered nurse was responsible for oversight and facilitating the implementation of the programme and has also completed an annual review of 2014 infection control activities. The review included linking the results of relevant audits to the infection control programme.</p> <p>Residents were offered annual influenza vaccinations. Signed consent</p>

		<p>forms were sighted in all four residents' files sampled by the second auditor. Staff are also offered annual influenza vaccinations.</p> <p>The RN advises there have been no residents identified with a notifiable disease since the last audit. Residents who develop an infection have care plans developed that detail staff interventions to minimise the spread of infection.</p> <p>The manager advises signage is placed on the door in winter requesting that visitors with cough, colds or influenza do not enter.</p> <p>A pandemic/outbreak box is sighted to contain supplies of protective equipment (PPE) for use in the event of an outbreak/pandemic.</p> <p>The manager and RN report having open communication processes. The manager feels well informed of all relevant issues, including infections, by caregiving staff and the RN.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The RN is responsible for facilitating/implementing the infection prevention and control programme. The RN has attended some relevant training for the role (refer to 3.4). The RN advised if additional support or advice was required the general practitioner would be contacted. Depending on the type of event advice/support could be obtained from the DHB gerontology team, the public health service, the Ministry of health, or the pharmacists. The RN advised the internet would also be used to seek relevant and current information. The RN advised that there have been no significant events since the RN's employment that required the RN to seek additional infection prevention and control advice.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Policies and procedures on infection prevention and control topics were readily available for staff. The policies were dated as reviewed in June 2014. The content of the policies was appropriate to the service setting and met current accepted practice. The notifiable disease schedule needs to be updated. The staff interviewed were aware of the policies and advised they would be reviewed if they were unsure of what to do.</p> <p>The ARRC contract requirements are met.</p>

<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The RN is responsible for providing infection prevention and control educations. The RN has attended three study days provided by an external infection prevention and control consultant in 2011 and certificates of attendance were sighted. The study days covered starting out in infection prevention and control, continence and wound management. The RN advised a study day attended in April 2013 also included the topic of wound management, including managing wound infections.</p> <p>Staff are provided with infection control education. The most recent in-service occurred in September 2014 and related to the management of urinary tract infections.</p> <p>Residents are provided with education on relevant topics. This includes prior to the influenza vaccination and in the event the resident developed an infection. The steps to prevent the spread of infection are documented as being discussed as a component of the care plan and these were sighted in applicable residents' files sampled.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance for residents with infections was occurring and was appropriate to the service setting. Caregivers were required to report to the RN and manager when they suspected a resident had an infection. The caregivers were able to identify the symptoms they would report and showed good understanding. Where applicable the RN and GP are informed. The shift handover was observed to include details when residents have been started on a treatment regime for a suspected infection. In addition, other activities, including the residents being offered additional fluids during the day to help minimise the risk of developing urinary tract infections during hot summer temperatures, were discussed.</p> <p>Suspected infections are reported on template forms and reviewed by the RN. The number and type of infections are analysed on a monthly basis and communicated to staff via the staff meetings. The infection surveillance included residents when treatment was continued or changed. The reported infection rates were likely to be higher than actual due to this reporting process. However, staff were aware of the organisation's processes and follow-up plans as related to individual resident's care.</p> <p>Short terms care plans have been developed and implemented when</p>

		<p>residents were identified as having infections. One resident has recently commenced prophylactic antibiotics to prevent urinary tract infections.</p> <p>The residents and family members interviewed confirmed staff keep them well informed of any changes in the residents' health and or changes in medication/treatment.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Glencoe Rest Home has a 'non-restraint' philosophy. There was no history of restraint or enabler use. A register was available. Staff had access to guidelines for the management of emergency situations. There were clear definitions on restraint minimisation and safe practice and enabler management. The staff interviewed had a good understanding of enablers and that they were only used in a voluntary capacity for safety purposes. Relevant training was not able to be evidenced in the last two years education records reviewed (as per criterion 1.2.7.5), however, training was planned for 2015 on de-escalation techniques and challenging behaviour management as documented on the education plan reviewed.</p> <p>Environmental restraint was acknowledged for the front gate which was locked for safety purposes as the rest home was on the corner of two main roads. A bell system for entry applied and consent was obtained from all residents/family/whanau on entry to the service. An instruction sheet was sighted and consent forms were signed appropriately. Four families and four residents interviewed verified there were no restrictions on residents accessing the facility and the community.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>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.</p>	PA Low	<p>The adverse event reporting policy includes the definitions of accidents, incidents, falls and injury. There is a template form that staff are required to use to report accidents and incidents and these forms are sighted to have been completed for applicable events documented in the residents' files sampled. This includes near miss events and medication related events. Where events have been reported there is evidence of investigation and appropriate follow-up. Short term care plans were sighted in the applicable residents' files reviewed.</p> <p>Incidents were observed to be discussed by staff during shift handover including any ongoing care required.</p>	<p>The incident report analysis summary did not include all reported events. For example, unwitnessed falls, while being reported, were not consistently included in the monthly data analysis.</p>	<p>Ensure all reported events are consistently included in the incident and/or accident analysis.</p> <p>180 days</p>

		<p>The staff report this was their normal practice.</p> <p>The number and themes of incidents and accidents were discussed and reported at the regular staff meetings as confirmed by staff interviewed and reported in the meeting minutes. While unwitnessed falls were being reported as an incident, all data was not currently included in incident/accident monthly analysis, for example, the months of October and December 2014.</p>		
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>The 2013, 2014 and 2015 education plan and associated education records were reviewed. There is good attendance by staff at the in-service education sessions. One staff member is working towards obtaining a diversional therapy certificate and two staff are working towards obtaining an industry approved qualification in dementia care.</p> <p>Staff reported that education most often occurs as a component of the staff meetings and the topics are relevant to their roles and responsibilities. A number of planned in-services scheduled for 2014 did not occur as planned.</p>	<p>The organisation could not demonstrate that all education required to meet the standards and/ or ARRC agreement have been provided within the last two years. For example, in-service/education on the Code and Advocacy service, restraint minimisation and managing challenging behaviours. An independent advocate has been booked to provide in-service on 27 January 2015.</p>	<p>Ensure education is provided within timeframes to meet the Health and Disability Sector Standards and Aged Related Residential Care Contract requirements and records are maintained.</p> <p>180 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly</p>	PA Moderate	<p>The manager identified there was a very stable staff of caregivers. The</p>	<p>The prospective owner had not as yet employed a registered nurse (RN) to</p>	<p>Ensure the prospective owner has recruited a</p>

<p>documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>		<p>caregivers interviewed during audit have been employed at Glencoe Rest Home for between 10 and 13 years.</p> <p>A policy detailed staffing requirements and this meets the ARRC contract requirements. There is at least one caregiver on duty at all times. Two caregivers are on duty between the hours of 7 am and 2.30 pm and between 5pm and 7pm each day. The caregivers are also responsible for cleaning and laundry duties. Designated time is allocated for diversional therapy five days a week (including weekends). There is a designated person on call 24 hours a day, seven days a week (24/7). Most often this is the manager who is also able to undertake caregiving activities if required. The manager also assists with food service and other day to day activities. The registered nurse works approximately 16 hours a week and this includes some quality and risk activities. The RN is also available to staff by telephone for urgent issues when not on site as confirmed with the RN, manager and other staff during interview. The RN role will become vacant at the end of January 2015. The manager advised that where required a registered nurse has been obtained from a nursing bureau and records sighted verified this. Where possible the same RN is requested to assist with continuity of care.</p> <p>All staff have a current first aid</p>	<p>provide services following the sale of the business. The current RN will cease employment at the end of January 2015.</p>	<p>registered nurse for the provision and oversight of residents' clinical care.</p> <p>Prior to occupancy</p>
---	--	---	--	--

		<p>certificate.</p> <p>All current staff have been offered employment by the prospective manager as confirmed during interview with the manager, the prospective manager and staff. A registered nurse has yet to be recruited by the prospective owner. The prospective owner has a staffing policy which meets the ARRC contract requirements.</p>		
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	<p>Eight medication records were randomly selected to review. Four of the eight records have not been completed appropriately by the prescriber.</p>	<p>Some short course medications which have been completed have not been signed or dated by the prescriber when discontinued.</p>	<p>Ensure all discontinued medications are signed and dated by the prescriber.</p> <p>180 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>An external company undertakes performance monitoring checking of one piece of clinical equipment. The tympanic thermometer and pulse oximeter have not been tested in the last 12 months. Weighing scales are reported to be hired from an external company when resident weights required to be checked.</p> <p>There was a building warrant of fitness sighted with an expiry date of 16 March 2015. The checks to maintain the</p>	<p>Electrical safety test and tagging of electrical appliances was overdue (due June 2014). Performance monitoring testing of the pulse oximeter and tympanic thermometer has not occurred in the last 12 months.</p>	<p>Ensure test and tagging of electronic equipment is current and all clinical equipment has performance monitoring tests completed on an at least an annual basis.</p> <p>180 days</p>

		<p>building warrant of fitness (BWOFF) have been signed as completed. The prospective owner has had external consultants undertake a building compliance review and stated they will be utilising this same company to maintain the BWOFF requirements as they also provide services in the prospective owner's other rest home.</p> <p>All electrical equipment appliances checked at random were overdue for electrical testing and tagging (ETT). The ETT labels on equipment were noted as being due for retesting in June 2014.</p> <p>The hot water temperature in residents' bedrooms has been checked. The most recent records (November 2014) confirmed that all temperatures were under 45 degrees Celsius.</p> <p>The facility vehicle had a current registration and warrant of fitness.</p>		
--	--	--	--	--

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.