Anglican-Methodist South Canterbury Glenwood HomeTrust Board

Introduction

This report records the results of a Surveillance 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:	Anglican-Methodist South Canterbury Glenwood HomeTrust Board
Premises audited:	Glenwood Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 22 June 2015 End date: 22 June 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 31

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Glenwood Home is operated by a trust board. Glenwood cares for up to 42 residents requiring rest home level care. On the day of the audit there were 31 residents. The facility manager has aged care management experience and has been at the service for 18 months and is supported by a clinical manager. Residents and family interviewed spoke positively about the service provided.

Nine of ten previous shortfalls have been addressed. These were around internal audits, essential notifications, staff orientation, performance appraisals, activities goals, care plan evaluations, referral to specialist services, medication competency assessments and dating and labelling of food. Improvement continues to be required around aspects of medication management. This audit identified improvements required around, staff meetings, resident's surveys and staff training.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

There is an open disclosure and interpreters policy that staff understand. There is a complaints policy supporting practice and an up-to-date register. Staff interviews confirmed an understanding of the complaints process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

Glenwood has a quality and risk management system in place which generates improvements in practice and service delivery. The service is active in analysing data. Corrective actions are identified and implemented. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers more than eight hours annually. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

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

Residents were assessed by a registered nurse on entry to the service and a baseline assessment which also formed the initial care plan was completed. Residents and family members interviewed stated that they were kept involved and informed about the

resident's care with input into care planning and evaluations. Re-assessments were conducted for long term residents or when a risk was identified; all care plans were recently reviewed with use of short term care plans for health changes.

Planned activities are appropriate to the residents assessed needs and abilities. Residents and family interviewed confirmed satisfaction with the activities programme and those not wishing to or able to attend group activities being offered individual activities.

Staff responsible for medicine management have current medication competencies. Medicine reviews are conducted at least three monthly. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Food service processes meet good practice residents reporting the food is at correct temperature and satisfaction with the menu.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were no residents requiring restraints and no residents using enablers. Staff are trained in restraint minimisation and the management of challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

Glenwood has an infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

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	14	0	2	1	0	0
Criteria	0	37	0	2	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Residents and their family/whanau reported they have been provided with information on admission. Complaint forms are available at the key points throughout the service. Staff interviewed (three caregivers, one registered nurse and the clinical manager) were aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There have been four complaints in 2015 to date (two written and two verbal). All have documented investigations and the two written complaints evidence that the complainant has been informed of the outcome. Residents and family members advised that they are aware of the complaints procedure and how to access forms.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents (six) and family members (four) interviewed stated they are informed of changes in health status and incidents/accidents. This is confirmed on incident forms reviewed. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings occur monthly and the manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken

		English the interpreter services are made available.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Glenwood Home is owned and operated by the Anglican-Methodist South Canterbury Glenwood Home Trust Board. The service provides care for up to 42 residents at rest home level care. On the day of the audit, there were 31 residents (including one resident on short term respite care). The service is been managed by an experienced manager who has been in the role for 18 months and receives support from an experienced clinical manager who had been at the service for five weeks and long standing care staff. The chair of the board expressed confidence in the manager. The manager was absent on the day of the audit. There is a 2015–2018 strategic plan that is in the process of being ratified. The current quality and risk management plans have been implemented with progress toward goals and achievement of these documented. The manager has completed at least eight hours of training related to management of a rest home in one-to-one sessions with an experienced contract clinical advisor.
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 manual and the quality and risk management planning procedures describe Glenwood's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored. There have not been regular staff meetings to discuss quality outcomes. Minutes for staff meetings that have occurred have included actions to achieve compliance where relevant. Discussions with the registered nurse and caregivers confirmed their involvement in the quality programme. Resident/relative meetings have been held. Data is collected on complaints, accidents, incidents and infection control. The internal audit schedule for 2015 has been commenced and is up to date. This is an improvement since the previous audit. Areas of non-compliance identified at audits have been actioned for improvement. There has been a relative survey but no resident survey. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. There is a death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death. Falls prevention strategies are implemented for

		individual residents.
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.	FA	Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Policy has been updated to include appropriate and timely reporting of outbreaks. This is an improvement since the previous audit. A sample of resident related incident reports for May 2015 were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise the risk of recurrence.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 20 years. The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. This was completed in staff files sampled and is an improvement since the previous audit. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff whose files were sampled. This is also an improvement since the previous audit. The staff in service training programme has recently been reviewed with appropriate training planned for 2015 and 2016. However staff have not had all required training and attendance records are incomplete for trainings that have occurred. The registered nurses attend external training including seminars and education sessions with the local DHB.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Glenwood has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is a full time clinical manager and a full time registered nurse who share on call duties. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each shift.
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 Moderate	An appropriate medicine management system was implemented in line with legislation and current guidelines. The service uses individualised medication blister packs which are checked in on delivery. Medicines and associated documentation are stored securely and all medication checks are completed and meet requirements. Resident photos and documented allergies or nil known were on all

		10 medication charts reviewed. Previous findings identified inaccurate administration and a lack of documentation to evidence G.P. medicine review at least three monthly. The diversional therapist was observed administering medications correctly at lunchtime and appropriately dealt with an unclear documented instruction. Eight of 10 charts reviewed were for residents who had lived in the facility more than three months and all had a G.P. sign-off of a medication review three monthly. These findings are now addressed. Documentation gaps on administration charts continued to be a required improvement. Not all as required medication has a documented indication for use. A previous finding identified that one registered nurse had not completed a medication competency. All staff completing medicine administration, including the registered nurses, have a current annual medication administration competency and medication training had been conducted. The issue has been addressed. There is a self-medicating policy however currently there are no residents who self-administer medicines.
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	Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. The menu is developed by a dietician and documentation confirming review of the menu was sighted. Meals are served in a central dining room and staff were observed assisting residents with their lunch time meal and drinks. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurses or caregivers, this was confirmed with sighting a recent change in nutritional requirement for a resident with weight loss. All food is prepared on site. A previous finding identified that decanted foods were not labelled or dated. Inspection of the food stores, fridges and freezers confirmed all foods, including decanted foods were dated. A rotational system for tinned foods ensured oldest foods were used first. Hot food temperatures are recorded immediately prior to serving and residents report the food is at correct temperature when served. Residents interviewed report satisfaction with the menu and food standard. Fridge and freezer temperatures are recorded and were within required range.

		All kitchen staff have received food safety training.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Five of five resident files reviewed confirmed care plans were current and interventions to meet care needs were documented. Interviews with staff and relatives confirmed involvement of families in the care planning process. Wound assessment and wound management plans were in place for the one resident with multiple wounds on the day of the audit with input by GP. When a resident's condition alters interventions to meet the resident's needs are developed and communicated to staff with use of short-term care plans and as a part of shift hand-over. Interview with residents and families confirmed all care needs were met with a high level of satisfaction.
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	One qualified diversional therapist and one activities coordinator provide an activities programme seven days of the week. The programme is planned monthly with a master copy on display; residents receive a personal copy weekly. Activities planned for the day are displayed on the notice boards throughout the facility. A previous finding identified that not all residents had activity goals and an activity plan. An activity plan which includes goals was sighted on five of the five files reviewed and rewritten as required. The activity plan is developed for each individual resident based on assessed needs and reviewed in line with the care plan review. The previous issue has been addressed. Residents are encouraged to join in group activities that are appropriate and meaningful and are encouraged to participate in community activities. Residents were observed participating in activities on the days of audit. Monthly resident meetings provide a forum for feedback relating to activities. At interview the diversional therapist detailed visiting residents who do not participate in the group activities offering individual activities. Residents and family members interviewed confirmed encouragement to participate in activities with choice given. Those that participated stated enjoyment in the programme and staff support to participate.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	A previous finding identified that there were not regular reviews and reassessment of resident risk areas. Three of the five resident files reviewed were for residents who had lived in the facility over six months, all three had a recent review process completed which included reassessment of relevant risk areas such as pain, falls, challenging behaviour, incontinence, nutrition and pressure area. Care plans were

		reviewed in line with the review and reassessment process and included all risk areas identified. This finding is closed A previous finding identified that wound assessment and monitoring was required. The clinical manager described an improvement process to further develop the short term and wound care plans and these were noted in use. One resident was receiving wound care for multiple wounds on the day on the audit and the wound care plan for each wound included goals, management, completed reporting of monitoring and evaluation. Two of the five resident files reviewed were for with had experienced changes in health status and the long term care plan had been updated in line with reassessment. G.P. three monthly medical reviews were documented in the three of five files of residents who had lived at the facility more than three months, more frequent medical assessment/ review was noted as occurring in residents with acute conditions or decline in health status. Evaluations are conducted by the registered nurses with input documented as from the resident, family, health care assistants, and diversional therapist, this was confirmed during interviews. There was recorded evidence of additional input from specialist or multi-disciplinary such as physiotherapy, dietitian and outpatient services in files sampled.
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	A previous finding identified the need to ensure referral to specialist services. Review of five resident files identified one resident exhibiting challenging behaviour had been referred for review by the needs assessment team and progress notes stated this had taken place however the clinical manager reported no documented outcome had been received. One resident had been referred to a physiotherapist and dietician for review with the assessment and recommended plans sighted on the resident's file with implementation stated in progress notes. The previous shortfall has been addressed.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness which expires on 1 May 2016.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance	FA	Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The registered nurse is the designated

with agreed objectives, priorities, and methods that have been specified in the infection control programme.		infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly resident infection summary sheet and then analysed and evaluated and reported to staff meetings (link 1.2.3.6).
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with staff. There were no restraints or enablers in use at Glenwood. Staff are trained in restraint minimisation and the management of behaviours that challenge.

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	There is a standard staff meeting agenda that includes matters arising from previous minutes, accidents and incidents, health and safety, infection control, resident care, internal audits and outcomes, risks and hazards and general business. Meetings have been held on 15 May 2015 and 18 June 2015 since the new clinical manager commenced. A relative survey was completed in 2015 with corrective actions completed following this.	(i) There were no staff meetings (where all quality matters are discussed) between January and May 2015. (ii)There has been no resident satisfaction survey in the past year.	(i) Ensure that staff meetings are conducted regularly. (ii) Ensure that resident satisfaction is monitored regularly. 90 days
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	The in service programme has recently been reviewed by the contracted clinical advisor and the shortfalls have been identified with a plan in place to address these. Training attendance records have been maintained for training that has occurred more recently. There is a	(i) Staff have not had on-going training around wound management, cultural safety or nutrition and hydration. (ii) Attendance records have not been documented for trainings that occurred prior to 2015.	Ensure staff complete all required training and attendance at trainings in documented. 180 days

		documented training plan for 2015.		
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 Moderate	There is no single general practitioner providing doctor services to the facility thus the service is dealing with 10 G.P.s. The service uses the Medico-Pak blister pack system with supporting documentation including the doctor prescribing chart and administration recording sheets.	(i) Three of the ten resident medication charts reviewed had 'as required' medicines charted that did not include indications of use. (ii) Four of ten administration records reviewed had gaps in times of day when medicines were expected to have been administered	Ensure as required medicine prescribing includes indications of use and documentation confirms all prescribed medicines have been administered. 60 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.