

Whitehaven Healthcare Limited - Glendale Retirement Home

Introduction

This report records the results of a Partial Provisional Audit; Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity: Whitehaven Healthcare Limited

Premises audited: Glendale Retirement Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 2 December 2015 End date: 3 December 2015

Proposed changes to current services (if any): Partial provisional audit conducted to assess the addition of six new bedrooms and two refurbished rooms. Two existing rooms have been changed in to office space.

Total beds occupied across all premises included in the audit on the first day of the audit: 25

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

Glendale rest home is privately owned and was purchased by the current owner in February 2015. The manager has been in the role under the new ownership since February, having previously been involved with Glendale as a manager and owner. The service is certified to provide rest home level of care for up to 30 residents. There were 25 residents at Glendale on the days of audit.

The certification audit was conducted against the Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

A partial provisional audit was also conducted to assess eight rooms – six new resident rooms and two refurbished rooms. The audit process included a review of proposed staffing and rosters, assessment of the new build and review of medication management systems and kitchen facilities.

The manager works full time and is supported by a registered nurse with considerable experience in aged care who commenced in the role in April 2015.

The service is implementing a quality risk management system. Residents, families and general practitioner interviewed commented positively on the standard of care and services provided at Glendale.

The certification audit identified no improvements required. The partial provisional audit identified that a new approved fire evacuation scheme is required prior to occupancy of the new rooms.

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.
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Glendale provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

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.		Standards applicable to this service fully attained.
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Glendale is implementing a quality and risk management system that supports the provision of clinical care. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an on-line education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Partial Provisional: the service has developed proposed rosters for increasing staffing requirements in line with the increase in 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.		Standards applicable to this service fully attained.
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Certification: Residents are assessed on entry to the service. There are entry and admission procedures in place which include interRAI assessments. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident and family/whanau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. The medication management system in place follows recognised standards and each resident is reviewed at least three monthly by their general practitioner. A range of individual and group activities are available and coordinated by the diversional therapist. All meals are prepared onsite and the kitchen is the hub of the rest home. There is a five weekly menu in place which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

Partial provisional: The existing medicine management system and the food service will accommodate the increased occupancy. No changes are planned to either system.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Certification: There is a current building warrant of fitness which expires on 20 December 2015. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Residents can and do bring in their own furnishings for their rooms. There is a lounge and dining area, and small seating areas throughout the facility. Furniture is appropriate to the setting and arranged that allows residents to mobilise.

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

Partial provisional: The facility has added six new resident rooms and refurbished two bedrooms. Three of the bedrooms can accommodate double occupancy. The new physical environment minimises harm to residents. The facility has increased to 33 bedrooms to 33 of which four bedrooms (three new and one existing) can be double occupancy, giving a total potential occupancy of 37 residents. Seven of the eight bedrooms have ensuite shower and toilets. In addition there is a new small lounge area, a new communal bathroom, a new laundry room (to replace the old laundry which has been converted to increase kitchen storage) and new outside decking. The external area requires no additional landscaping. A Certificate for Public Use has been issued on 16 October 2015, which expires on 1 February 2016. Appropriate equipment and amenities are in place. There is sufficient space to accommodate the entertainment, recreational and dining needs the additional residents. The hours of the cleaning staff will be extended as occupancy increases. There will be no change to existing laundry practices, which will continue to be provided by caregivers. The existing emergency management system will accommodate the increased occupancy. A new fire evacuation

scheme will need to be approved prior to occupancy of the six new rooms and an application has been lodged with the New Zealand Fire Service. The existing electronic call system is operational in the new areas. Each new room has access to external light, and there are appropriate heating and ventilation systems in place.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation is practiced and overseen by the registered nurse. There are no residents using enablers or restraints.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control co-ordinator. There is a suite of infection control policies and guidelines that meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated.

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	44	0	1	0	0	0
Criteria	0	92	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Glendale rest home has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Three caregivers, one diversional therapist and one registered nurse (RN) were able to describe how they incorporate resident choice into their activities of daily living. The service actively encourages residents to have choices and this includes voluntary participation in daily activities as confirmed on interview with five residents.</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</p>	FA	<p>The service has policies and procedures relating to informed consent and advanced directives. All five files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.</p>

to make informed choices and give informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. Interviews with residents and family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is regularly discussed at resident meetings (minutes sighted).</p> <p>Residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the residents' family and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Interview with residents confirm relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs and interest groups in the community. Residents confirm the staff help them access community groups.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice which aligns with Right 10 of the Code. The manager leads the investigation of concerns/complaints. Complaints forms are visible and available for relatives/residents. A complaints procedure is provided to residents within the information pack at entry. The service has received no formal complaints in the past three years. The complaints register is up to date. Management operate an "open door" policy.</p>
<p>Standard 1.1.2: Consumer Rights</p>	FA	<p>There is a welcome pack provided to residents on entry that includes information on how to make a complaint, Code of Rights pamphlet, advocacy and Health & Disability (HDC) Commission. Relatives and residents are informed of</p>

<p>During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>any liability for payment of items not included in the scope of the service. This is included in the service agreement. Residents and five family members interviewed confirmed they received all the relevant information during admission.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>There are policies in place to guide practice in respect of independence, privacy and respect. Resident preferences are identified during the admission and care planning process with family involvement. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents interviewed confirmed staff respect their privacy, and support residents in making choice where able. Staff have completed education around privacy, dignity and elder protection.</p> <p>Resident files are stored securely. There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings were documented in the five resident files sampled.</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>Glendale has a Maori health plan and a cultural safety policy that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Currently there are no residents who identify as Maori. Linkages with Maori community groups are available and accessed as required.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<p>The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the residents needs are being met. Discussion with family and residents confirm values and beliefs are considered. Residents are supported to attend church services of their</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>choice.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the five staff files sampled. Staff comply with confidentiality and the code of conduct. The RN and allied health professionals practice within their scope of practice. Management and staff meetings include discussions on professional boundaries and concerns/complaints as they arise (minutes sighted). Interviews with the manager, the registered nurse and care staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Glendale policies and procedures meet the health and disability safety sector standards. Staff state they are made aware of new/reviewed policies and sign to say they have read them. An environment of open discussion is promoted. Staff report the manager and registered nurse are approachable and supportive. Allied health professionals are available to provide input into resident care. Staff complete relevant workplace competencies. The RN has access to external training. Discussions with residents and family were positive about the care they receive.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The manager and registered nurse confirm family are kept informed. Relatives stated they are notified promptly of any incidents/accidents. Families receive newsletters that keep them informed on facility matters and events. Resident meetings encourage open discussion around the services provided (meeting minutes sighted).</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.</p> <p>There is access to an interpreter service as required.</p>

communication.		
<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>	FA	<p>Certification: Glendale rest home provides care for up to 26 rest home level of care residents. On the day of audit there were 25 residents which included two younger persons under long term chronic health condition contracts. There were no respite residents.</p> <p>The service has a business plan which is reviewed annually. The business plan identifies the purpose, values and scope of the business. The service has quality goals which are reviewed monthly at the staff/quality meetings. The owner has owned Glendale since February 2015. The manager has a long history with Glendale – having been a previous owner. The manager has been in the role since February 2015. The manager is supported by an experienced registered nurse with a background in aged care. The registered nurse has been in the role since April 2015.</p> <p>The manager has completed at least eight hours of professional development including regional provider meetings, and a managers training day.</p> <p>Partial Provisional: The addition of six new rooms and the refurbishment of two existing rooms is documented in the current business and quality plan goals. Glendale ownership and management structure will continue as is. The manager is well supported by the owner, with at least weekly communication via email and phone calls. The manager reports to the owner on matters relating to occupancy and finances.</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>	FA	<p>Certification: The registered nurse provides cover in the absence of the manager as required. A nurse assistant (previously enrolled nurse) is employed to provide assistance and support to the manager, registered nurse and care staff.</p> <p>Partial Provisional: The service intends to employ an additional registered nurse for up to 16 hours per week. The current registered nurse will continue to provide cover for the manager in her absence.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	FA	<p>Glendale is implementing a quality and risk management system. The provider completes monthly reviews against service goals. Goals for 2015 include building and refurbishment of eight rooms (six new and two existing), refurbishment of the laundry, new kitchen storage area, fire proofing existing rooms to building code standards,</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>integration of InterRAI assessment tool, promotion of the service, strengthening relationships with residents, family and the community. The service has purchased a new sling hoist.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies. Assessment policies have been updated to include reference to the use of the InterRAI assessment tool.</p> <p>Monthly staff/quality meeting minutes sighted evidence staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons, trends and graphs are displayed for staff information. The registered nurse and three caregivers interviewed were aware of quality data results, trends and corrective actions.</p> <p>Annual resident and relative surveys are conducted with excellent results achieved for 2015. Results have been collated and results fed back to participants and staff as evidenced in meeting minutes.</p> <p>There is an internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Any areas for improvement are identified and implemented. A monthly summary of internal audit outcomes is provided to the staff meetings for discussion. Corrective actions are developed, implemented and signed off. Reviews and audits are conducted more frequently where issues are identified.</p> <p>There is an implemented Health and Safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirm they are kept informed on health and safety matters at meetings.</p> <p>Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls.</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</p>	<p>FA</p>	<p>Accident/incident forms for the months of October and November 2015 were sampled (24). There has been RN notification and clinical assessment completed within a timely manner. Accidents/incidents were also recorded in the resident progress notes. There is documented evidence the family had been notified promptly of accidents/incidents.</p> <p>The service collects incident and accident data and reports aggregated figures to the staff/quality meeting and the health and safety meeting. Staff interviewed confirm incident and accident data are discussed at the staff meeting and information and graphs are made available.</p> <p>Discussions with the manager confirms an awareness of the requirement to notify relevant authorities in relation to</p>

<p>to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>essential notifications.</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>FA</p>	<p>Certification: There are human resources policies to support recruitment practices. Five staff files sampled contained all relevant employment documentation. Current practising certificate was sighted for the registered nurse and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>There is an education planner in place that covers compulsory education requirements over a two year period. The RN has completed InterRAI training. Clinical staff complete competencies relevant to their role.</p> <p>Partial Provisional: The manager advised that existing part time care staff will be offered extra shifts in the proposed roster. Further care staff will be recruited as resident numbers increase and as required. The service intends to employ an additional registered nurse for 16 hours per week. Existing recruitment practices will be implemented in the procurement of new staff.</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>FA</p>	<p>Certification: The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager is on-site full time and available after hours. The registered nurse is on duty Monday to Friday for 32 hours per week – which is an increase from previous audit of 24 hours per week. The RN also provides after hours on-call. The registered nurse assistant also provides on-call cover for non-clinical issues. The caregivers, residents and family interviewed inform there are sufficient staff on duty at all times.</p> <p>Partial Provisional: The proposed roster for the increase in residents includes the addition of an RN for 16 hours per week, additional caregivers on morning shift from 7 -1.00pm, afternoon shift 3 -11.00pm and night shift 10.45 – 7.15am. The cleaning hours are to be extended by up to 2 hours per day, the cook shift extended by up to 2 hours per day and activities hours extended by 8 hours per week to cover Saturday and Sunday.</p>
<p>Standard 1.2.9: Consumer Information Management</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information is kept confidential. Entries were legible, dated and signed by the relevant caregiver or registered nurse including</p>

<p>Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>designation. Files are integrated.</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>	<p>FA</p>	<p>There is a policy in place to guide resident admissions. Needs assessments are required prior to entry to the facility. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on services available. Residents and or family/whanau are provided with associated information (e.g., information on their rights, the Code, complaints management, advocacy, and the admission agreement). Family members and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. The current version of the admission agreement aligns with the expectations in the aged residential care agreement and includes exclusions from the service.</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>	<p>FA</p>	<p>The service has transfer and discharge policies and procedures in place. The procedures include the use of the DHB developed (yellow envelope) system to manage information during transfer and discharges. All residents transferred or discharged are noted on interRAI by the registered nurse.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe</p>	<p>FA</p>	<p>Certification: The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. The service uses a four weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicine are stored securely when not in use. Controlled drugs are supplied weekly when prescribed and managed according to the guidelines. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the</p>

<p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>pharmacy. Medication orders include indications for use of 'as needed' medicines. Short life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior caregivers with medication administration responsibilities (medicine competencies for the registered nurse and 12 caregivers were sighted). Administration sheets are appropriately signed. Ten medication charts reviewed identified that the GP had seen the resident three monthly and the medication chart was signed each time a medicine was administered by staff. One caregiver was observed administering medications and followed correct procedures. Three residents self-administer medicines. They have access to secure storage in their rooms. Staff check each shift that these residents have safely self-administered their medications and record this on the medication administration sheet. Residents/relatives interviewed stated they are kept well informed of any changes to their medications.</p> <p>Partial provisional: There is an established medicines management system in place. There are policies and procedures in place for safe medicine management that meet legislative requirements. There is a dedicated medicine room and medicines trolley. The existing system will be capable of accommodating the increased occupancy.</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>	<p>FA</p>	<p>Certification: There is a fully equipped commercial kitchen, which is located centrally in the rest home. The majority of food is prepared and cooked on site. There is one cook who works Monday to Friday 8.30am to 1.30pm (interviewed) and there be a weekend cook who works 9.30am to 1.00pm. There is a tea shift person who works 4.30pm to 7.30pm, seven days a week to serve and manage the evening meal. The main meal of the day is served at lunch time. All kitchen staff have completed food safety training. There is a five weekly rotating menu in operation. The menu was last reviewed by a dietitian on 29 May 2015 and the dietitian's recommended actions have since been implemented. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served directly from the kitchen to residents in the dining room or to their rooms as required. A tray service is available if required by residents. All food in the freezer and fridge is labelled and dated. Food procurement occurs from commercial operators. Kitchen waste is collected by commercial operators. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for and currently the kitchen is catering for a resident who prefers gluten free meals. Alternative meals can be accommodated if needed. Resident's weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices, and meals which were well presented. There is a cleaning schedule in place.</p> <p>Partial provisional: There is an established system in place which will be able to accommodate the additional number of residents.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service has a process for declining entry should this be necessary. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. Management have not had to decline entry to prospective rest home residents. The reason for declining service entry to residents would be recorded and communicated to the resident/family/whānau and alternative options suggested if appropriate.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>An initial nursing assessment and initial care plan is completed within 24 hours of admission by the registered nurse. Personal needs, outcomes and goals of residents are identified. There are a range of assessment tools completed on admission and reviewed six monthly or earlier if the resident's health status changes. All new residents admitted have an interRAI assessment completed within 21 days of admission. Assessment process and the outcomes are communicated to staff at shift handovers and through the clinical record. The assessment tools link to the individual care plans, which include interRAI outcome scores. The general practitioner completes a medical admission with two working days. All residents and relatives interviewed were satisfied with the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The initial care plan is developed from the initial interRAI assessment process and the needs identified by the registered nurse in consultation with staff. Comprehensive long term care plans are individually developed with the resident and/or family/whānau who sign to acknowledge their approval of the care plan. Residents and family members interviewed stated they are involved in the care planning process. All resident comprehensive long term care plans reviewed were evidenced to be up to date. Nursing diagnosis, goals and outcomes are identified and agreed and how care is to be delivered is explained. Care plans are individualised for each resident. All care plans reviewed recorded sufficient detail to guide care staff. Activities care plans were completed for all files reviewed. Residents are seen by the GP at least three monthly or more frequently if required. The GP records progress in the medical records and notes reviews on the resident's medicine management charts. Short term care plans are in use.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Service delivery is guided by the resident's plan of care. The interRAI assessment process informs the development of the care plan. Care plans are goal orientated and reviewed at six monthly intervals. The five caregivers, one nurse assistant and one registered nurse interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights are monitored monthly or more frequently if necessary. There is currently one resident with wounds. Assessment and management plans were in place for this resident. There was evidence of input from the GP, the DHB vascular team and from district nurses who are providing onsite compression bandaging twice weekly. The registered nurse has completed wound competency and compression bandaging training in September 2015 provided by the DHB wound care nurse specialist. The resident was interviewed and was happy with the current management plan.</p> <p>Specialist nursing advice is available from the DHB as needed. All falls are reported on the resident accident/incident form and reported to the registered nurse and manager. A falls risk assessment is completed on admission and reviewed at least six monthly or earlier should there be an increased falls risk. A physiotherapist referral to the community physiotherapy service can be initiated as required.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</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>There is one qualified diversional therapist (DT) employed who is responsible for the planning and delivery of the individual and group activities programme with assistance from staff. The DT typically works 10.00am to 3.30pm, Monday to Friday. DT hours are flexible to allow for attendance and organisation of special events at weekends and evenings. Caregivers assist the DT with individual and group activities programmes during the week and at weekends. The DT meets with other DTs operating in the area every few weeks and attends workshops twice a year.</p> <p>Group activities are provided in the large communal dining room, in seating areas, and outdoors in the gardens when weather permits.</p> <p>Individual activities are provided in resident's rooms or wherever applicable.</p> <p>On the days of the audit residents were observed being actively involved with a variety of activities including external entertainers. The group activities programme is developed monthly and a copy of the programme is available in the lounge, on noticeboards and in each resident room. The group programme includes residents being involved within the community with social clubs, churches and schools.</p> <p>The DT interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan which is then reviewed six monthly as part of the interRAI, care plan review/evaluation process.</p>

		<p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>Glendale has its own van for transportation which seats 11 people and one driver. The DT drives the van and has a current first aid certificate. Residents interviewed described weekly van outings, musical entertainment and attendance at a variety of community events.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents are reassessed using the interRAI process at least six monthly or if there has been a significant change in their health status. Long term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. Care plan reviews are signed as completed by the RN. The GP reviews residents three monthly or when requested if issues arise or their health status changes. The GP was interviewed and stated that the staff communicate appropriately. Short term care plans were evident for the care and treatment of residents. Short term care plans were in place for one resident with vascular ulcers, a resident who needed to increase weight, and residents with pain management issues. Short term care plans are typically used for residents with infections and those who have significant changes in their medicines management regime.</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>The service facilitates access to medical and non-medical services. The registered nurse interviewed confirms that residents, family and the resident's GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to medical specialists are made by the GP in consultation with the registered nurse. Relatives and residents interviewed stated they are informed of referrals required to other services and are provided with options and choice of service provider where applicable.</p>
Standard 1.4.1:	FA	<p>Certification: There are policies and procedures in place for waste management. Residents, staff and visitors are</p>

<p>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>		<p>protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use information is available. Protective equipment including gloves, aprons, and goggles are available for use by staff. Staff interviewed were familiar with accepted waste management principles and practices.</p> <p>Partial Provisional: There will be no changes to the existing waste management system which will be able to accommodate the additional occupancy.</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>FA</p>	<p>Certification: The facility is two storied. It has a current building warrant of fitness, which expires on 20 December 2015. Assessment for hot water temperatures checks are conducted monthly. Hot water is provided at 45 degrees maximum in resident areas. Medical equipment includes a hoist, chair scales, a blood pressure machine and thermometer. The hoist was purchased new in July 2015. Clinical measuring equipment (i.e., BP and chair scales) were last calibrated by an authorised technician on 12 June 2015. Electrical equipment was last tested on 16 December 2014.</p> <p>The first floor area can be accessed by two flights of stairs. One stairwell has an electronic stair chair lift, which had its last annual service in May 2015.</p> <p>There are five single resident rooms located upstairs. These residents have access to a tea making area as well as a communal shower and toilet. The diversional therapist's office and storage is located upstairs.</p> <p>On the ground floor there are 20 bedrooms of which bedroom Number 2 is a double room (currently occupied by a single occupant). Two of the existing bedrooms were refurbished as part of the renovation. There is a large communal lounge and dining area and a small sitting area. Some bedrooms have ensuite facilities. Others share ensuites and some use communal facilities. There are sufficient communal toilets adjacent to the lounge and dining areas. There is a small internal seating area at the entrance available for residents and visitors. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors. The exterior by the entrance is well maintained with safe paving, outdoor shaded seating, lawn and gardens and car parking. Interviews with the registered nurse and the caregivers confirmed that there was adequate equipment to carry out the cares according to the resident's care plans.</p> <p>Partial Provisional: The facility has recently added six bedrooms (of which three can accommodate double occupancy). Two existing bedrooms were redesigned and refurbished to include ensuites. The renovations now</p>

		provide a total of 33 bedrooms, of which four bedrooms can be used for double occupancy, giving a total potential occupancy of 37 residents. Seven of the eight bedrooms have ensuite shower and toilets. There is a small lounge, one new communal bathroom, a new laundry room (to replace the old laundry which has been converted to kitchen storage) and new outside decking. No additional landscaping is required. Appropriate equipment and amenities are in place and will accommodate and increase in occupancy. The new physical environment minimises harm to residents. A Certificate for Public Use has been issued on 16 October 2015 which expires on 1 February 2016.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	<p>Certification: There are five single rooms upstairs, which use a communal toilet and shower and have hand basins in their bedroom. On the ground floor there are ten rooms with a shared full ensuite, two rooms with a shared ensuite toilet and one room with its own toilet, the other rooms share three communal bathrooms. The number of visitor and resident communal toilets provided is adequate. Hand washing and drying facilities are located adjacent to the toilets. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets and showers are well signed and identifiable and include vacant/engaged and in-use signs.</p> <p>Partial Provisional: Seven of the eight bedrooms include hand basins, toilets and shower ensembles. The eighth bedroom has a hand basin only and this resident will use a new communal bathroom that includes a toilet and shower, which has been installed in close proximity to the bedroom. The communal bathroom has an engaged signage on it. Staff and visitors will continue to use the existing toilet facilities.</p>
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	<p>Certification: The rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. All beds are of an appropriate height for the residents. Caregivers interviewed report that rooms have sufficient room to allow cares to take place. Bedrooms are personalised.</p> <p>Partial provisional: The new rooms can accommodate residents' personal needs. They are spacious and three of the new rooms are of sufficient size to accommodate double occupancy.</p>
Standard 1.4.5: Communal Areas For	FA	Certification: There is a large lounge and dining room and small seating areas which are used for activities, recreation and dining activities. The dining room is spacious, and located directly off the kitchen/servery area. All

<p>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>areas are easily accessible for residents. The furnishings and seating are appropriate. Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed report they can move around the facility and staff assist them if required. Residents advised that while the stalled building work has been less than ideal, there have been few interruptions to their daily life and routine.</p> <p>Partial Provisional: There is sufficient space to accommodate the additional residents for communal entertainment, recreation and dining. There are multiple sitting areas throughout the facility. The new small lounge can accommodate an additional 11 residents.</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>	FA	<p>Certification: There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the care staff. Staff attend infection prevention and control education and there is appropriate protective clothing available. Care staff complete laundry tasks. Cleaners are employed seven days a week to clean from 9.30 am to 1.30 pm and can do additional hours as needed. Manufacturer's data safety charts are available for reference if needed in an emergency. Residents and family interviewed report satisfaction with the laundry service and cleanliness of the facility.</p> <p>Partial provisional: The human resource plan is for the cleaning hours to be extended as occupancy increases (link #1.2.8). When there is full occupancy, cleaning hours will be extended to finish at 3.30pm daily. There will be no change to existing laundry practices which will continue to be provided by caregivers.</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>	PA Low	<p>Certification: The service has a fire and emergency procedures manual. The Evacuation Scheme was approved by New Zealand Fire Service on 13 July 2011. The last fire drill was conducted on 19 June 2015. There is currently a trained person with a first aid certificate on each shift. Fire safety training has been provided. There is an electronic call bell system in place. A civil defence kit is stocked and checked monthly. Water is stored, sufficient for at least three days. Alternative heating and cooking facilities are available. Emergency lighting is installed. A generator is available when needed. Staff conduct checks of the building in the evenings to ensure the facility is safe and secure. The facility has a mix of gas and electric hot water. There are emergency management plans in place to ensure health, civil defence and other emergencies are included.</p> <p>Partial Provisional: An application has been lodged with the New Zealand Fire Service for a new fire evacuation scheme, which will need to be approved prior to occupancy of the six new rooms. The existing electronic call system has been installed in the new areas and is operational. There is no change required to the existing emergency management plan.</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>Certification: All communal and resident bedrooms have external windows with plenty of natural sunlight. The facility is heated by a mix of underfloor electric heating, wall panels and heat pumps (all of which are electric). Windows and ranch sliders open for ventilation. The general living areas and resident rooms were appropriately heated and ventilated on the day of audit. Residents and family interviewed state the environment is comfortable.</p> <p>Partial Provisional: New bedrooms have underfloor heating, and external windows to the internal courtyard for ventilation and natural lighting.</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>The registered nurse is the infection control coordinator. The infection control coordinator job description has identified delegated responsibility for infection control within the service. The infection control coordinator provides a monthly report to management and staff. The infection control programme has been reviewed in February 2015.</p> <p>Visitors are asked not to visit if they have been unwell. Influenza vaccines are offered to residents and staff. There are hand sanitizers throughout the facility and adequate supplies of personal protective equipment. There have been no outbreaks.</p> <p>Partial Provisional: The infection control team consists of the manager, the registered nurse and the RN assistant. The infection control team will remain in place with the increase in resident numbers and remains appropriate to the size and scope of the service provided.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources</p>	FA	<p>Infection control is managed by the infection control coordinator (registered nurse). The infection control coordinator has maintained current knowledge of infection prevention and control. The infection control coordinator has access to infection control personnel within the district health board, laboratory services and the GP.</p>

<p>to implement the infection control programme and meet the needs of the organisation.</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>	<p>FA</p>	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed.</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 infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education has been provided in the past year. Staff receive education on orientation and one on one training as required.</p> <p>Resident education occurs at resident meetings such as use of sanitizers and hand washing. Hand hygiene posters have been placed in all resident toilet areas.</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>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place are appropriate to the size and complexity of the facility. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Restraint minimisation is practiced. The registered nurse oversees the restraint process within the facility. There are policies around restraint, enablers and the management of residents who may exhibit behaviours that challenge. The service currently has no residents using enablers or restraints. Any resident requiring restraint or who exhibited behaviours that may challenge would be reassessed to determine their suitability to continue to reside in the rest home.</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)
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Low	Partial Provisional: The building has an existing evacuation scheme which was approved by New Zealand Fire Service on 13 July 2011. There is an existing emergency management plan in place to guide staff in the event of a civil defence emergency.	The six new bedrooms are not covered by the existing fire evacuation scheme. The manager advised an application has been lodged with the New Zealand Fire Service for a new fire evacuation scheme and the fire evacuation scheme provider is booked to review the new build area in early December 2015. The Fire Service advised by correspondence that the current evacuation scheme is valid until the new approval has been provided, which has to be obtained prior to occupancy.	Provide evidence that an approved fire evacuation plan covering the new bedrooms is obtained prior to occupancy. Prior to occupancy 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, 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.