

Udian Holdings Limited - Glencoe Resthome

Introduction

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

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

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

The specifics of this audit included:

Legal entity:	Udian Holdings Limited
Premises audited:	Glencoe Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 December 2015 End date: 2 December 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:	12

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
Yellow	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
Red	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

Glencoe Rest Home provides rest home level care for up to 15 residents. There are 12 residents receiving care on the day of audit including one short stay resident.

There have been no significant changes to the land and facility since the last audit, with the exception of some electrical work in the corridors and general maintenance. The owner has another rest home in Auckland.

This certification audit was conducted against the Health and Disability Services Standards. The audit process included the review of policies and procedures, review of clients' files and staff files, observations, and interviews with clients, family members, staff (including the general practitioner) and management.

There is a coordinated quality and risk programme that is implemented. Feedback from clients and family members is very positive about all aspects of the care and services provided.

The audit identified seven areas for improvement required to meet these standards. These include: consent; maintaining the complaints register; ensuring the owner participates in ongoing education; and recording staff orientation. Ensuring staff handling food have completed food safety training; that all staff members' have current medication competencies; and ensuring falls incidents are linked with evaluations are also areas requiring improvement.

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.		Some standards applicable to this service partially attained and of low risk.
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Staff demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of health and Disability Services Consumers' Rights (the Code). Families and residents interviewed expressed high satisfaction with the caring manner and respect that staff show towards each resident.

There are two residents who identify as Maori residing at the service at the time of audit. There are no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written consents are obtained from the residents' family/whanau, enduring power of attorney (EPOA) or appointed guardians. Signed and/or verbal consent however was not sighted to acknowledge that residents and family members are aware of security cameras operating in external and internal communal areas of the facility. Documentation of informed consent was also not evident to show that a resident was unable to access an external gate without staff assistance.

Residents are encouraged and supported to maintain community and family links.

Staff, residents and family members are aware of the complaints process. There is a high level of satisfaction expressed in relation to services provided. A recent complaint has not been added to the complaints register and actions taken in response to the complaint have not yet been documented.

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.
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The owner purchased Glencoe Rest home in February 2015 and is on site at least 20 hours a week and is responsible for ensuring the day to day needs of residents are met. Records are not available to demonstrate that the manager has attended eight hours of education in the last year related to managing a residential care facility (as required to meet the provider's contract with Counties Manukau District Health Board). The owner is supported by a registered nurse and a manager. The mission, philosophy and goals of the rest home are documented and monitored.

The quality and risk programme provides the framework for the service and includes complaints and compliments, incident and accident reporting, surveillance for residents with infections, audits, satisfaction surveys, policy/procedure review and risk and hazard identification and management. The results of quality and risk activities are discussed with staff regularly at monthly staff meetings, or sooner during shift handover where applicable. Corrective action plans are developed where required, implemented and monitored for effectiveness.

Most of the staff have worked in the rest home prior to the current owner purchasing the facility or have transitioned from the owners other rest home. Employment contracts, confidentiality agreements and job descriptions are on file. Staff performance appraisals have been undertaken. Staff and contractors providing services have annual practising certificates where this is required.

An orientation programme is provided for new staff; however records have not been retained. The registered nurse and manager commenced employment at Glencoe in February 2015 and are on call when not on site. Staff have participated in regular relevant on-going education. Staffing numbers and skill mix is appropriate.

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

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 low risk.
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Pre-admission information clearly and accurately identifies the services offered. The service has policies and processes related to entry into the service.

Residents on admission to the service are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops, with the resident and family, a care plan specific to the resident. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan, however not all six monthly care plan evaluations consistently evidence linkages with information noted in the incident reporting process. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All residents have interRAI assessments completed and individualised care plans related to this programme.

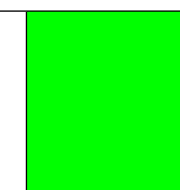
Residents are reviewed by their GP on admission and assessed thereafter either monthly or three monthly by their GP depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

Activity coordinators provide planned activities meeting the needs of residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their residents.

A safe medicine administration system was observed at the time of audit, however the registered nurse's medication competency was sighted as out of date.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes are catered for. The service has a four week, summer/winter rotating menu which is approved by a registered dietitian. Resident's nutritional requirements are met, however not all staff responsible for preparing and cooking food have relevant food and safety training.

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


The building has a current building warrant of fitness. Clinical equipment has a current calibration. Electrical safety checks of electrical appliances have been undertaken in 2015. New security cameras have been recently installed. The front gate has a keypad lock.

There are 11 single occupancy bedrooms and two share twin bedrooms. All have hand washing facilities present. There is one full bathroom with a toilet and shower and three separate toilets for residents use. Call bells are present in the bedrooms and bathrooms. Personal space is sufficient, including for those who require staff assistance or the use of mobility devices. There is a separate lounge and dining area. There is good indoor/outdoor flow with deck and garden areas for the residents and their families to use. The facility has adequate heating and ventilation. Smoking is allowed in a designated outside area.

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

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

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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The service has a commitment to a `non-restraint policy and philosophy`. The restraint minimisation and safe practice policy complies with the standard. There were no enablers in use at the time of the audit. Staff interviewed had a good understanding that the use of enablers was a voluntary process. Physical restraints are not used; however, one resident is unable to independently open the locked gate without assistance. Consent processes have not been completed for this and this environmental restraint is raised as an area for improvement in the consumer rights section of the standards.

Staff have access to education on managing challenging behaviour and safe and effective alternatives to restraint at orientation.

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.

The service has an appropriate infection prevention and control management system. The infection control programme is implemented and provides a reduced risk of infections to staff, residents and visitors. Relevant education is provided for staff and when appropriate the residents. There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported and discussed at staff and resident meetings.

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	38	0	7	0	0	0
Criteria	0	86	0	7	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>The rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with a copy of the Code on admission and a copy is displayed on the main corridor wall in full view for residents, caregivers and visitors.</p> <p>On commencement of employment all staff receive induction orientation training regarding residents’ rights and their implementation. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give</p>	PA Low	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents’ files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA). Advance directives are signed by the resident if competent. Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in their relative’s care and</p>

<p>informed consent.</p>		<p>decision making. Informed consents were not evidenced to identify that residents and families were aware of camera's that filmed external and internal communal areas of the facility. Consent was also not evidenced for one client who is unable to open the external gate without support of staff or a family member.</p> <p>Residents interviewed stated that they were able to make their own choices and felt supported in their decision making. Staff interviewed acknowledged the resident's right to receive, refuse and withdraw consent for care/services. Staff were able to demonstrate good knowledge around challenging behaviours as evidenced in progress notes, care planning and observed at the time of audit.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>All residents receiving care within the facility have appropriate access to independent advice and support, including access to cultural and spiritual advocate whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident's progress notes and care planning, such as visiting the library or their marae.</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>	<p>PA Low</p>	<p>The complaints policy detailed the residents or family member's right to make a complaint. The process for reporting, investigating, documenting and following up the complaint was documented and the timeframes aligned with the requirements of the Code.</p> <p>All residents and family members interviewed confirmed being aware of the complaints process and have no complaints. The staff and managers interviewed were able to detail their responsibilities in the event a resident made a complaint.</p> <p>A complaints register was sighted. It did not include details of all complaints and actions taken in response to a complaint. Other complaints had been acknowledged, investigated and responded to in a timely manner.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The standard operating procedures identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission.</p> <p>The family/whanau and residents that were interviewed reported that the Code was explained to them on admission and was also provided as part of the admission pack. The Code of Rights and process was also regularly discussed at family/resident meetings. Family/whanau and residents expressed that they were happy with the care at the facility and provided by the staff.</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>The residents' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The family/whanau interviewed reported that staff often go above and beyond families' expectations when meeting the needs of their relatives.</p> <p>The family/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted.</p> <p>The family/whanau interviewed expressed no concerns in relation to residents' abuse or neglect. The family members reported that staff know their relatives well and are very good at intervening prior to and with any potential challenging behaviours. This was also evidenced at the time of audit.</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>The facility is committed to identifying the needs of its residents and ensuring that staff are trained and capable of working appropriately with all residents in their care. They are in consultation, involved and participate with the local iwi. This was evidenced by knowledge of a local iwi kaumatua who visits, and residents who belong to different marae.</p> <p>The clinical coordinator/RN and nurse manager/RN reported that there are no barriers to Maori accessing the service. At the time of the audit there were two Maori residents. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture. This was also evidenced in care plans expressing the resident's specific and individual needs in relation to their Maori culture and beliefs. The resident and relative/whanau interviewed confirmed that they were happy with the service and had no concerns.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The spiritual, religious and cultural standard operating procedure documents that the admission process includes assessing specific cultural, religious and spiritual beliefs, which includes any cultural nutritional requirements. Staff liaise with family/whanau to ensure cultural or religious visits continue as appropriate.</p> <p>Education on cultural sensitivity and spirituality has been completed. Families and relatives interviewed were happy with the care provided by those staff who also identify with a different culture and enjoy different cultural days that are organised within the facility and within the community.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidence-based practice was observed and evidenced in interviews with the clinical coordinator/RN and caregivers and care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' GPs, links with the mental health services, hospice, the geriatrician and the DHB. Care guidelines are utilised as appropriate.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff.</p> <p>At the time of audit all residents and relatives spoke English and did not require interpreting services.</p> <p>The family/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidence adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at handover.</p>
<p>Standard 1.2.1: Governance</p>	PA Low	<p>Glencoe Rest home has a documented mission statement and philosophy on care that is focused around the provision of individualised, resident focused care that maximises independence within a</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>homely environment. The owner and manager monitors the progress in achieving these goals via the internal audit process and review of resident and family satisfaction. The owner and the manager have an 'open door' for residents and family. A number of goals/objectives are set for the forthcoming year and these are monitored and documented once completed.</p> <p>The day to day operations and ensuring the wellbeing of residents is the responsibility of the owner who has owned this rest home since February 2015 and is on site at least 20 hours a week and is on call when not on site. The owner has another rest home in Auckland (purchased in October 2009). Records are not available to demonstrate the owner has participated in more than eight hours of education relevant to managing an aged care service as required to meet the provider's contract with Counties Manukau District Health Board.</p> <p>A new manager has been employed (February 2015) and lives on site. The manager participates in relevant ongoing education.</p> <p>The RN, who is the clinical co-ordinator commenced employment at Glencoe in February 2015 and is on site four days a week (32 hours a week). The clinical co-ordinator is on call when not on site.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the owner's absence the clinical co-ordinator and the manager share the responsibilities for performing the owner's role (refer to 1.2.1.3). An experienced RN employed at the owners other rest home is available for advice and support if this is required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>There is a documented quality and risk plan and this was sighted.</p> <p>Policies and procedures are available to guide staff practice. The policies are developed by an external consultant and then reviewed and localised to reflect Glencoe Rest Home by the clinical co-ordinator. Changes in policy are discussed at staff meetings as verified by staff and managers interviewed and reference in meeting minutes. Document control processes are implemented and out of date policies are archived.</p> <p>A review of the quality and risk programme is undertaken via monthly staff meetings. The minutes of four meetings were reviewed and included discussions on individual resident's needs, hazards, complaints and compliments, changes to policies/procedures/practices, the results of audits, security,</p>

		<p>education, the use of restraint, infection data and the number and type of reported incidents. The management team have an 'open door' to staff and residents/families.</p> <p>Internal audits have been undertaken and are conducted using template forms. A schedule is included in the quality policy detailing what audits are to be undertaken and when. The six audits sampled during audit identified there is good compliance by staff in meeting the requirements of the organisation's policy and the audit criteria. Where improvements were required these improvements have been documented, implemented and monitored. Short term care plans are utilised to document follow-up for applicable incidents. While corrective actions have been taken following complaints, these are not always documented (refer to criterion 1.1.13).</p> <p>A resident satisfaction survey was conducted. Only one response has been received to date (August 2015). The manager advised consideration is being given on how to improve the response rate for future surveys.</p> <p>Resident meetings are held every month. Minutes sighted reflected discussion on food, the activities programme, staff and facility cleanliness. Resident compliments were recorded and communicated to staff. Education has been provided to residents on infection prevention and control topics.</p> <p>Staff are required to report any hazards. Where hazards/maintenance concerns have been identified these have been eliminated or minimised. A hazard register was available that detailed a range of hazards related to the facility/environment as well as resident care. The mitigation strategies have been detailed. The hazard register was last reviewed in February 2015.</p> <p>A risk management plan is in place. Organisation risks are categorised and documented and mitigation strategies noted. The owner and the manager were able to discuss changes in organisation risk.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident and accident reporting policy which is implemented by staff. A new event reporting form has been introduced. Applicable events are being reported, investigated and responded to in a timely manner. The clinical co-ordinator advises the caregivers phone and advise of resident related events in the event the RN is not on site.</p> <p>Resident care plans are used to provide guidance for the caregivers following reported incidents. The sample of incident reports reviewed at random including medication errors, resident falls, skin tear/wounds, episodes of challenging behaviour, and missing property demonstrated prompt reporting, investigation and follow-up was occurring. Reported events are discussed at the monthly staff meetings as confirmed by staff interviewed and verified in the meeting minutes sighted.</p> <p>A register is maintained each month of all reported events. The register details the date, resident and details of each event. The number and type of incidents is analysed for each month. The resident care</p>

		<p>plan evaluations sampled did not reference falls events (refer to 1.3.8.2).</p> <p>The owner and clinical co-ordinator are able to detail the events that require notification and this includes the Ministry of Health, the DHB, the coroner, the Ministry of Business and Innovation. Details of these events are included in policies. The owner and manager advises there have been no events that have required notification since the purchase of the business except that related to the change of ownership process.</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>	PA Low	<p>Policies detail the process that is required related to human resources practices. The policy aligns with current accepted practice. The majority of staff were employed by the previous owner and continued under the new owner. Two staff have transferred in from the owner's other rest home. The manager was employed in February 2015. The owner has registered to undertake police checks for future employees.</p> <p>Annual practising certificates (APC) for registered health professionals are verified as being current. The APC for the general practitioner had expired two days prior to audit. A copy of the current certificate was obtained during audit. Records for the RNs and pharmacists are current. The driver's licence for applicable staff and managers are current.</p> <p>Staff confirmed they are provided with an orientation to the facility, individual residents and to their individual role and responsibilities. Records, however, are not consistently available to evidence this.</p> <p>Staff have undergone a performance appraisal since February 2015.</p> <p>Staff ongoing education is planned and provided. The education is appropriate to the service setting and includes in-service education on site as well as access to external education. Records of attendance are maintained.</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>	FA	<p>A policy details staffing requirements and this meets the ARRC contract requirements. There is at least one caregiver on duty at all times and the owner, manager and clinical co-ordinator are on call when not on site. This is confirmed by staff and managers interviewed. Staff have a current cardiopulmonary resuscitation certificate and caregivers have a current medication competency. The caregiver's share responsibility for resident care, cleaning and laundry services over the 24 hour period. The manager assists with food services. An activities coordinator is employed for 16 hours a week, rostered over at least three changing days each week (including weekdays and weekends).</p> <p>The registered nurse works 32 hours a week (Monday, Tuesday, Wednesday and Friday) as noted on the roster and is contactable via phone if there are urgent issues outside of the rostered hours.</p>

		Residents and family members interviewed advised the residents received timely and appropriate care from all staff.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all resident's information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's record reviewed. No personal or private resident information was observed to be on public display during the days of audit</p> <p>Archived records were being safely held on site for seven years. These are catalogued for easy retrieval.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has an admission/enquiry form that records pre-admission information. At the time of the audit all residents were over the age of 65. The resident admission agreement is based on the Aged Care Association agreement. The resident's records reviewed have signed admission agreements by the resident/family or EPOA.</p> <p>Vacancies are updated daily through Eldernet. Staff contact the facility manager or clinical co-ordinator if enquiries are made by potential perspective residents and/or their family members.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service uses the DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA Low	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording,</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>process when an error occurs as well as definitions for 'over the counter' medications that may be required by residents. The sighted policies meet the legislative requirements and best practice guidelines.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in locked medicine trolley in the office which is locked when not occupied. A locked metal container is used for controlled medications, the medicine register was sighted. Medications that require refrigeration are stored in a separate fridge.</p> <p>The 10 medicine charts reviewed have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (prn) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administers medicines. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident and a pharmacy medication/tablet identifying sheet. At the time of audit there were no residents who were self-administering.</p> <p>There are documented competencies sighted for designated care staff as responsible for medicine management, however medication competency for the registered nurse was overdue by two months. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management. Senior caregivers are assessed six monthly to be competent with medication as required.</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>PA Low</p>	<p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and were sighted and meet the food safe requirements. Kitchen staff interviewed have a very good understanding of food safety management, however only one of all staff responsible for preparing and cooking of food has completed a food and safety course.</p> <p>There is a four week rotating menu with summer and winter variations. The menu has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with</p>

		<p>food and nutritional snacks 24 hours a day.</p> <p>All meals are cooked and served directly from the kitchen at the time of the meal, with residents having the option of trays in their rooms. Residents were observed to be offered a second.</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 clinical co-ordinator interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</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>The service has implemented the electronic interRAI assessment for all residents. The service continues to use organisational paper based assessment tools to complement the interRAI assessment. Assessments are carried out by a RN appropriate to the level of care of the resident and include falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life, self-medication and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The residents' files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure ulcer risk assessments.</p> <p>The family/whanau interviewed reported their resident receives 'above and beyond the care required' to meet their relative's needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p>	FA	<p>The five residents' files reviewed have care plans that address the resident's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the residents' files. Also evidenced is the assessment of</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>techniques used that is individual and specific to the resident with interventions and evaluations sighted. The caregivers interviewed demonstrated knowledge about the individual resident's they care for.</p> <p>Five residents' files reviewed included diversional therapy care plans identifying the resident's individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files reviewed showed input from RNs, care and activities staff, and medical and allied health services. The RN and caregivers interviewed reported they receive adequate information to assist with the resident's continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</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>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the day of the audit, the registered nurse and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. Staff were seen to pre-empt and redirect/distract residents with challenging behaviours promoting quality of life, independence, choices and safety of the residents as individuals and in group settings. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals. The registered nurse and caregivers interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</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</p>	<p>FA</p>	<p>The activities programme uses a framework to empower the residents to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinator adapts activities to meet the needs and choices of the resident.</p> <p>The facility has one activity co-ordinator who works a total of 16 hours per week. The 16 hours are flexible and worked within a 7 day working week (including weekends) to allow for different activities</p>

<p>the service.</p>		<p>and community events occurring.</p> <p>The weekly activities plan/calendar sighted is developed based on the residents' needs and interests and can be easily adapted and changed depending on the residents' interest and reaction at the time. The activity coordinator advertises the upcoming activities on the calendar by providing residents on the notice boards through the facility. The caregivers assist with the planned activities seven days a week. Regular activities include church services, happy hour, regular visiting entertainment and includes trips to other events occurring in the community such as weekly craft day and community set events. Daily activities occur within the main lounge. Activities focus on the five senses and reminiscing, including current affairs. For residents that wish to remain in their rooms, activities and one to one interaction is offered and encouraged by staff. The care staff interviewed state that they have access to activities to support residents after hours and on the weekends.</p> <p>The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements over a 24 hour period. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file six monthly.</p> <p>Family/whanau interviewed report that they are always encouraged to partake in the activities with their residents and supported when taking their relatives out into the community. Family/whanau report that there is a wide range of interesting and different exciting activities and events that occur.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans are sighted for wound care, pain, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents' progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover. Information specifically related to incident of falls was however not evident in the evaluations of three of five residents' files sighted.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or</p>

		there are changes in the resident's condition.
<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>There is one GP who either visits the resident at the facility or a family member or clinical co-ordinator will take the resident to see the GP in the practice when required due to the resident's choice. The RN or the GP arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The GP interviewed reported that referrals to requested services are well managed from the facility and no concerns are noted.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Policies detail how waste is to be segregated and disposed. The policy content aligns with current accepted practice.</p> <p>Chemicals sighted were stored in designated and secure areas. Material safety data sheets and a reference wall chart on actions to take in the event of exposure were sighted for chemicals in use. The washing machine has been fitted with an auto dispenser for laundry products.</p> <p>Appropriate personal protective equipment (PPE) is available on site including disposable gloves, aprons, masks, and face protection. The staff interviewed on this topic detailed what PPE was required to be worn by staff and when, in order to minimise risk of exposure to blood and other body fluids and contaminated items/equipment.</p> <p>Staff advise they would report any inadvertent exposures to hazardous substances and blood and body fluids via the incident reporting system.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There is a current building warrant of fitness (expiry 16 March 2016). An external company undertakes performance monitoring and electrical safety checking of clinical equipment. Electrical equipment checked at random have a current electrical testing and tag label. Clinical equipment has undergone performance monitoring testing and clinical calibration in April 2015. Hot water testing is conducted of the kitchen and at least two residents' rooms/areas every month. The temperatures in resident areas are at 45 degrees Celsius.</p> <p>The vehicle used to transport residents to appointments and activities have a current registration and warrant of fitness. Staff driving the vehicle have a current driver's licence and a copy is held in the staff</p>

		<p>members file.</p> <p>Grab rails are present in the patient shower and toilet areas. There are handrails in the corridors. Small cracks are starting to appear in some areas of the floor. This has been noted in the facility hazard register and replacement linoleum is scheduled to occur in early 2016 as per the strategic plan. Some electrical work has been undertaken in the corridors in the last year.</p> <p>The bathroom floors have non slip linoleum floor covering. Furniture and fixtures were appropriate to the service setting. Residents have personalised their rooms.</p> <p>The residents' bedrooms are of a suitable size. The residents and family members interviewed confirmed the facility is appropriately furnished to create a home like environment.</p> <p>There was a number of external chairs that residents and family can utilise including on the deck and under the shade of trees.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>Hand basins are present in each resident's bedroom. Waterless hand gel is also readily available for staff.</p> <p>There was one bathroom with a shower and toilet and three separate residents' toilets. A shower register details the days of the week residents are to be offered showers and the time of the day the resident prefers to have a shower. The staff interviewed advised there are enough bathroom and shower facilities for the residents' use. Privacy locks are present on bathroom doors. There is a separate bathroom for the use of staff. No resident or family member interviewed expressed any concerns about the facility.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There are 11 single occupancy rooms and two double occupancy rooms. The rooms contained sufficient space for the residents, personal possessions and use of mobility devices if required. Privacy curtains are present in the twin rooms to optimise resident privacy. Residents are sighted mobilising independently inside and outside the rest home independently.</p> <p>The staff interviewed advised there is sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed were satisfied with the environment.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation,</p>	FA	<p>There is a lounge and separate dining area that residents and their family or visitors can use. There is a separate alcove at the end of one of the corridors where the residents' telephone is located along with</p>

<p>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>two arm chairs. There is also a shaded furnished area on the veranda and outdoor furniture throughout the garden/grounds. The residents and family members interviewed confirmed that there is sufficient space available for consumers and support persons to use in addition to the residents' bedrooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Policies detailed how the cleaning and laundry services are to be provided. The caregivers share these duties over a 24 hour period. The residents and family members interviewed confirmed the rest home is normally kept clean and tidy and residents' laundry is washed and returned in a timely manner. One resident completed the resident satisfaction survey (August 2015) and was satisfied with these aspects of service. Environmental cleaning is discussed at the resident's monthly meeting. The minutes feature compliments for staff on how the facility is kept clean and tidy.</p> <p>Audits laundry services were undertaken in June 2015 as scheduled on the audit calendar. The reports demonstrated initially some small improvements were required in staff processes. The follow-up audit in July 2015 verifies these have been addressed. Cleaning audits are also scheduled to occur on the annual audit schedule.</p> <p>Chemicals are stored in designated secure cupboards. Instructions for managing emergency exposures to chemicals is readily available to staff.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The fire evacuation plan has been approved by the New Zealand Fire Service (NZFS) in a letter dated 8 May 1999. A subsequent letter from the NZFS in November 2015 has recommended the plan be reviewed and updated. The owner advises a revised plan has since been lodged with NZFS electronically and a copy of this document was sighted. A fire evacuation drill was last conducted on 20 November 2015 and the records were sighted.</p> <p>Policy documents and a wall mounted emergency 'flip chart' located in the staff office includes guidance for staff on responding to a range of emergency events, including (but not limited to) earthquake, flooding and volcanic eruptions. Staff were provided with training on emergency events and security in April 2015 and records were sighted.</p> <p>A review of the staff files and training records verifies all staff have a current first aid certificate.</p> <p>There are supplies available of drinking water, lighting, blankets and other clinical supplies for use in emergency. A sufficient store of dry food stuffs was also available and this is kept separately from 'in use' food.</p>

		<p>Call bells are present in the bathrooms and residents' bedrooms. They alert audibly and a light also illuminates outside the applicable room. Two call bells tested at random were fully functioning.</p> <p>The caregivers interviewed advised the external doors and windows are routinely checked and locked prior to darkness. A repeat check occurs at the time of night shift handover and then regularly throughout the night. A number of security cameras have been installed in the last few months. These monitor outside the building and inside in the dining room, lounge, kitchen, and corridors. Images are displayed on a monitor in the staff office area and are archived electronically for up to a one month period. The manager can review images remotely at any time. Related consent/communication processes are included in the area for improvement raised in criterion 1.1.10.2.</p> <p>The gate at the entrance to the facility has a pin code and residents and family members are provided with the code. The code is also written on the bottom area of the keypad panel. All (but one resident) is able to independently enter and exit via the gate. (Refer to criterion 1.1.10.2). An intercom is present at the front gate, and security cameras are present for other visitors to call for staff.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are windows present in all residents' bedrooms. Doors and windows are sighted open during the audit. Heating is provided when required from two wall mounted heat pumps in the corridors and another heat pump is present in the lounge. There are wall mounted heaters present in each resident's bedroom.</p> <p>The residents and family members interviewed confirmed the facility was always warm and well ventilated.</p> <p>There is a designated area outside for residents who smoke. Staff and visitors are required to smoke off site.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>The infection control coordinator is the clinical coordinator/registered nurse. The infection control coordinator holds accountability and responsibility for following the programme in the infection control manual. The infection control coordinator monitors for infections by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meetings. If there is an infectious outbreak this is reported immediately to staff, management and where required to the DHB and public health departments.</p>

		<p>The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, staff communication book, one to one, shift handover and in resident's documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns were observed and found in all showers and toilets. Residents who have infections are encouraged to stay in their rooms if required.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The clinical coordinator/registered nurse has the role of infection prevention and control coordinator. Infection control issues are discussed at staff and resident meetings. The facility has the support of a clinical infection control specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources including the laboratory diagnostic services and GP. The infection control coordinator has undertaken a course in infection prevention and control through the Ministry of Health online training website. The registered nurse and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed</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</p>	FA	<p>An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including antibiotic use, MRSA screening, bandaging, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>

are practical, safe, and appropriate/suitable for the type of service provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The registered nurse/clinical co-ordinator and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the clinical coordinator. Infection control in-service education sessions are held and resident education is provided, as and when appropriate.
<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>	FA	All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report. The service monitors urinary tract infections, respiratory tract infections, skin and wound infections which include cellulitis/tissue/wound infections and scabies, eye infections and gastroenteritis. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff meetings. Infection rates are reported as being normally low, however infection rates for chest infections were elevated in July and September of this year. The monthly analysis evidenced reflected that the same residents were affected in both months due to their chronic medical history and discussion was had on how to reduce, minimise risk, trends and actions to take to reduce the infection rate.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Glencoe Rest home has policies and procedures that promotes a 'restraint free' environment. The policy includes definitions of restraints and enablers and these align with the standards. The clinical co-ordinator is the restraint coordinator. Staff and the clinical co-ordinator advise there have been no residents requiring personal restraint since the last audit. Use of restraint is discussed at the monthly staff meetings as verified in meeting minutes sampled. Staff were provided with training on restraint minimisation in April 2015 and again in September 2015 along with management of challenging behaviours. There was good attendance at both in-services. Staff could identify processes in emergency situations if the use of restraint was being considered. The staff interviewed had a good understanding of enablers and that they were only used in a voluntary capacity for safety purposes.</p> <p>All residents except one are able to independently enter and exit the facility and the locked gate without assistance. The resident that is unable to utilise the keypad or exit button mechanisms is independently mobile. The patient's next of kin is very aware of this and is very satisfied that the patient is unable to leave the grounds without being accompanied by either a family member or staff due to safety concerns. Documentation of any staff conversations or consent for environmental restraint is not sighted</p>

		<p>during audit. This is included in the area for improvement raised in criterion 1.1.10.2. The entrance code is known by the other residents and family members. Residents were sighted during the audit to be entering and exiting freely.</p> <p>One other family member and the five residents interviewed identified there are no restrictions on residents coming and going freely from the facility.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.2</p> <p>Service providers demonstrate their ability to provide the information that consumers need to have, to be actively involved in their recovery, care, treatment, and support as well as for decision-making.</p>	PA Low	<p>Security cameras are in use at the facility. Minutes from a family meeting evidence that the purpose of the cameras was discussed, but not all residents and family members were present at the time. There is no information in the welcome pack, consent forms or evidence of signs within the facility acknowledging that cameras are present.</p> <p>All staff are aware that a resident is unable to access the external gate without assistance. The resident's family member verbally expressed that they are happy that the resident is unable to access outside the gate on their own due to diminished capacity and safety issues.</p>	<p>Security cameras have being recently installed and monitor external and internal communal areas including the lounge, dining room, staff office, kitchen and hallway areas. Not all residents and family interviewed are aware of these cameras. Security camera footage is archived for up to one month.</p> <p>One resident is unable to open the external gate without staff assistance. The resident has diminished cognitive capacity. The resident's family member interviewed is happy the resident is unable to independently leave</p>	<p>Ensure residents and family are informed of the use of security cameras and records are retained to demonstrate this.</p> <p>Ensure that in the event a resident is unable to independently leave the premises</p>

			the premises. There is no documentation in the resident's record to acknowledge this aspect of care or consent for environmental restraint.	without assistance that informed consent is able to be demonstrated. 90 days
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>A complaints register was sighted and details complaints received since February 2015. There have been very few complaints received. The most recent complaint (early November 2015) has not been entered onto the complaints register. While staff can detail what has happened in response to this complaint, the actions undertaken have not yet been documented.</p> <p>The owner and manager advise there have been no complaints to the Health and Disability Commissioner, the DHB or the Ministry of Health (MOH) since the last audit.</p>	<p>The complaints register does not include details of the most recent complaint (November 2015) and actions undertaken in response to the complaint, although an acknowledgment letter was sent to the complainant.</p>	<p>Ensure the complaints register is maintained and includes all required documentation.</p> <p>180 days</p>
<p>Criterion 1.2.1.3</p> <p>The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.</p>	PA Low	<p>The day to day operations and ensuring the wellbeing of residents is the responsibility of the owner who purchased the rest home in February 2015. The owner is on site at least 20 hours a week and is on call when not on site. The owner has another rest home in Auckland and shares time between both sites. Records are not available to demonstrate the owner has participated in more than eight hours of education in the last year relevant to managing an aged care service as required to meet the provider's contract with counties Manukau District Health Board (CMDHB).</p> <p>A new manager has been employed (commencing February 2015) and lives on site. The manager is new to the aged care sector in New Zealand. The manager has worked overseas in information technology. The manager advises she completed a social work qualification overseas as an early</p>	<p>Records are not available to demonstrate that the owner has attended eight hours of education relevant to managing an aged care service in the last 12 months as required to meet the aged related residential care (ARRC) contract with Counties Manukau District Health Board (CMDHB).</p>	<p>Ensure records are available to demonstrate that the person responsible for managing (as detailed in the ARRC contract) completes at least 8 hours of relevant education every year.</p>

		<p>career choice. Records to verify this training were not sighted. The manager has to date completed two modules of a New Zealand industry approved qualification, and over eight hours of education relevant to managing an aged care service.</p> <p>The registered nurse (RN) is also the clinical coordinator, and trained overseas and then completed the requirements for New Zealand registration. The RN has completed a certificate in healthcare management after arriving in New Zealand and the certificate of completion was sighted. The clinical co-ordinator has worked in aged care in NZ since 2013 including the other rest home owned by the owner. The clinical co-ordinator participates in relevant ongoing education.</p>		180 days
<p>Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>Staff confirmed they are provided with an orientation to the facility and to their individual role and responsibilities. The orientation includes being supernumerary for a period of time and working with experienced staff. Staff advised the orientation prepared them for their role and included health and safety, quality and risk, policy/processes and individual resident care needs. Records, however, are not consistently available to evidence the orientation programme. There is also a checklist to be completed and this was omitted for the new manager and the two staff who transferred in from the owner's other rest home.</p>	<p>While new staff advise they have been provided with an orientation to the facility and residents, records of this process have not been maintained for the two new staff/managers.</p>	<p>Ensure records are retained to demonstrate that staff and managers complete the orientation programme.</p> <p>180 days</p>
<p>Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function</p>	PA Low	<p>The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management. The medication competency test sighted was completed in full and the person deemed as competent, however the required annual medication competency is overdue by two months.</p>	<p>The registered nurse medication competency was last completed in August 2014.</p>	<p>Ensure that all staff responsible for medication management undergo competency assessments on at least an</p>

for each stage they manage.				annual basis. 180 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	All staff interviewed who work in the kitchen at the time of audit have a very good understanding of food safety management, however only the manager has a certificate to verify completion of a food safety training programme. None of the other staff responsible for preparing and cooking of food in the facility have completed a food and safety course.	Records are not available to demonstrate that all staff involved with food preparation/cooking have completed food safety training.	<p>Ensure that staff involved with food services have completed approved food safety training and records are available to demonstrate this.</p> <p>180 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	Assessments such as challenging behaviours, wounds and assessment tool outcomes were evidenced in long term care plan evaluations and multidisciplinary meetings and evidence of discussion with families and/or significant others and referral to external resources was documented in the progress notes. Staff interviewed demonstrated that they were aware of the specific needs of the residents to reduce and minimise risk. Three of five residents' files reviewed did not show evidence in the evaluations referencing falls (as reported via the incident reporting system).	The six monthly care plan evaluations do not consistently evidence linkages with information obtained via the incident reporting process. As an example three of five residents' files reviewed did not include in the evaluation that the resident had fallen in the preceding six month period. One resident had had three falls.	<p>Ensure that relevant information from incidents and accidents is included in the resident's evaluations.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.