

# Grace Comfort Care Limited - Glenhaven Resthome

---

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Grace Comfort Care Limited

**Premises audited:** Glenhaven Resthome

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 24 October 2017      End date: 24 October 2017

**Proposed changes to current services (if any):**

**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.

## General overview of the audit

Glenhaven rest home provides rest home level care for up to 24 residents. On the day of the audit there were 12 residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owner. The provisional audit was conducted against the health and disability standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, staff and management.

The current owner/manager provides operational and strategic leadership for the service and has owned the rest home for the last three years. He is supported by a clinical nurse manager, senior caregivers and long serving staff. Residents interviewed were complimentary of the service and care they receive at Glenhaven Rest home.

The prospective owner reported the current policies, systems and staff will remain in place following the purchase. The current owner/manager will continue to provide support to the new owner for at least three months following purchase.

The provisional audit identified areas for improvement around training.

## **Consumer rights**

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is evident in the entrance and on noticeboards. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family. Residents interviewed spoke positively about care provided at Glenhaven Rest home. Complaints processes are implemented, and complaints and concerns are managed. Annual staff training reinforces a sound understanding of residents' rights and their ability to make choices.

## **Organisational management**

Glenhaven rest home has a quality and risk management system that is being implemented. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazard management. There is a monthly staff/quality meeting that includes health and safety, infection control, review of incidents and accidents and discussion of quality and risk. Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times.

## **Continuum of service delivery**

There is information available for residents and relatives prior to entry to the service. Residents are assessed prior to entry to the service. Care plans are individually developed with the resident, and family involvement is included where appropriate. Care plans are evaluated six monthly or more frequently when clinically indicated. Residents interviewed confirmed that the care plans are consistent with meeting residents' needs. Risk assessment tools and monitoring forms are available to assess effectively, the level of risk and support required for residents. Activities are provided that are meaningful and ensure that the resident maintains involvement in the community. A medication management system is implemented. All caregivers who administer medications have completed annual competencies for medication administration. There are three-monthly general practitioner medication reviews. The menu is designed by a dietitian with summer and winter menus. Dietary requirements are provided where special needs are identified.

## **Safe and appropriate environment**

Glenhaven rest home has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Medical equipment and electrical appliances have had electrical checks. There is a designated laundry which includes the safe storage of cleaning and laundry chemicals. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the rest home and dementia areas, which include lounge and dining areas, and smaller seating areas. Emergency management policies and procedures implemented, guide staff actions in the event of an emergency. Six-monthly fire evacuation drills are conducted. There is a civil defence kit and evidence of supplies in the event of an emergency in line with civil defence guidelines. There is a staff member on duty at all times with a current first aid certificate. External garden areas are available with suitable pathways, seating and shade provided.

## **Restraint minimisation and safe practice**

The service maintains a restraint free environment. There are policies and procedures to follow in the event that restraint or enablers were required. On the day of the audit there were no residents using restraints or enablers. The clinical nurse manager is the restraint coordinator. Restraint education is included in the two-yearly training programme.

## **Infection prevention and control**

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	44	0	1	0	0	0
<b>Criteria</b>	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 service has available information on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Advocacy pamphlets and the Code are clearly displayed at the main facility entrance. Six residents interviewed confirmed that information has been provided around the Code. No relatives visited on the day of audit. There is a resident rights policy in place. Discussion with two caregivers identified that they were aware of the Code and could describe the key principles.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent and resuscitation orders were appropriately recorded as evidenced in five of five resident files reviewed. Advised by staff that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Five sighted resident admission agreements were signed.</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>Residents and families are provided with a copy of the Code and advocacy pamphlets on entry. Resident advocates are identified on admission. Nationwide Health and Disability Advocacy service information is part of the admission pack. Interviews with the residents confirmed their understanding of the availability of advocacy services. Caregivers interviewed were aware of the resident's right to advocacy services and how to access the information.</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>The service has an open visiting policy and family and friends are encouraged to visit the home and are not restricted to visiting times. Residents interviewed stated that they are supported and encouraged to remain involved in the community. The service has a van and group outings are provided. Community groups visit the home as part of the activities programme.</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>FA</p>	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the owner/manager using a complaint's register. There have been two complaints made in 2016 and three complaints received in 2017 year-to-date. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainant. Residents interviewed advised that they are aware of the complaints procedure.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is a welcome information folder that includes information about the Code. There is opportunity to discuss this prior to entry and/or at admission with the resident, family or legal representative. The owner/manager is available to discuss concerns or complaints with residents and families at any time. Residents interviewed stated they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.</p> <p>The prospective new owner is currently employed as a facility manager at a retirement home and has also owned five facilities over the past 10 years. She is knowledgeable in the Health &amp; Disability Commissioner</p>

		Code of Rights and applies the code in practice in her current role.
<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>	FA	The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintain resident privacy. Staff sign a privacy declaration on employment. The owner/manager is the privacy officer and has an open-door policy. The education programme includes privacy/dignity and abuse and neglect, however these training sessions have not been included in the last two years (link 1.2.7.5). Care staff interviewed stated they promote independence with daily activities where appropriate. Resident's cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan to ensure the resident receives services that are acceptable to the resident/relatives.
<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>	FA	There is a Māori health plan and ethnicity awareness policy and procedure. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau. The service has established a link with local iwi who provides advice for staff and advocacy for Māori. On the day of the audit there were no residents that identified as Māori.
<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	The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognises and responds to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular on-site church services and attending other community groups as desired. Staff attended cultural awareness training in March 2017.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion,</p>	FA	The staff employment process includes the signing of a service Code of Conduct. Professional boundaries are defined in job descriptions. Staff

<p>harassment, sexual, financial, or other exploitation.</p>		<p>are observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with caregivers could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The owner/manager is committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. All residents interviewed spoke positively about the care provided. The service has implemented policies and procedures from a recognised aged care consultant to provide a good level of assurance that it is adhering to relevant standards. Staff interviewed had a sound understanding of the principles of aged care and state that they feel supported by management.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Management promote an open-door policy. Residents are aware of the open-door policy and confirmed on interview that the staff and management are approachable and available. Information is provided in formats suitable for the resident and their family. Residents and family are informed prior to entry of the scope of services and any items that are not covered by the agreement. Communication with family members is recorded on the incident report forms and in the resident daily progress notes. Eleven incident forms reviewed confirmed that family were notified following a resident incident. The information pack is available in large print and advised that this can be read to residents. Interpreters are available as required.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Glenhaven rest home can provide care for up to 24 residents requiring care at rest home level (six double rooms). On the day of audit there were 12 residents, including one younger person with disabilities (YPD). All other residents are under the aged related residential care (ARRC) agreement. The service has a business plan for 2017 in place. The</p>

		<p>business plan includes documented mission, philosophy and goals.</p> <p>Glenhaven rest home is managed by an owner/manager who has owned and operated the rest home for the last three years. The owner/manager provides operational and strategic leadership for the service. The owner/manager is on-site four days a week. The owner/manager and his mother are owner/directors. The company is supported by an accountant for financial matters and accounts. The owner/manager is supported by a registered nurse (clinical nurse manager) who has been in the role since April 2017. The clinical nurse manager provides clinical support and oversight of the service and has over three years' experience in aged care nursing. The owner/manager and clinical nurse manager have maintained at least eight hours annually of professional development related to managing a rest home.</p> <p>The prospective new owner (interviewed in person) has worked in the aged care industry for over 18 years and has owned five facilities over the past 10 years, with the last facility being sold in November 2016. She is currently working as a facility manager in an aged care facility since March 2017. The current owner will transition the prospective new owner into the facility and support them through the process for a three-month period. The clinical nurse manager and caregivers will remain employed under the prospective new owner. The new owner will take on a management role.</p> <p>The expected settlement date is for November 2017. The DHB is aware of the pending change of ownership. The prospective new owner confirmed that there will be no changes to management, staff, clinical systems, policies or procedures during the first year of ownership. The prospective new owner will continue current memberships with established professional bodies.</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>During the temporary absence of the owner/manager, the clinical nurse manager is the acting manager with the support from the care staff. The same arrangement will continue in the event of temporary absence of the prospective new owner.</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 management system and all aspects of service delivery are reviewed by a clinical advisor. The service has in place a range of policies and procedures to support service delivery that have been developed by an aged care consultant and are reviewed regularly. The service has an annual meeting schedule in place and staff and quality improvement meetings are held monthly. The staff have input into the monthly staff/quality meetings. Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of reviews against all aspects of the service by a clinical advisor. Corrective action plans are documented with evidence of resolution of issues. Quality improvement data is analysed and discussed at staff and quality meetings. Staff interviewed report that they are kept informed of quality improvements. There are monthly resident meetings for those who wish to attend. Residents interviewed stated that these are useful.</p> <p>The owner/manager and clinical nurse manager facilitate the quality programme and ensures the internal audit schedules are followed. Corrective action plans are developed and signed off when service shortfalls are identified. There are resident surveys conducted annually. The survey for August 2017 evidences that residents are overall satisfied with the service provided. Health and safety policies and procedures are in place for the service, which includes a documented hazard management programme and a hazard register for the service. Any hazards identified are signed off as addressed or risks are minimised or isolated. There is a designated health and safety representative (clinical nurse manger). Falls prevention strategies are implemented for individual residents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>The prospective new owner confirmed on interview there will be no changes to the current quality and risk management system or policies and procedures. The current owner/manager will be available to mentor the prospective new owner to the quality risk system.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>corrective actions. Eleven incident forms reviewed from July/August 2017, evidenced that appropriate clinical care is provided following an incident. Reports were completed, and family notified as appropriate. All incident forms are signed off by the clinical nurse manager. The caregivers interviewed could discuss the incident reporting process. The clinical nurse manager collects monthly incidents, investigates and implements corrective actions as required. Discussions with the owner/manager confirmed that he is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are human resources policies to support recruitment practices. The clinical nurse manager and the clinical advisor have a current annual practising certificate with a copy on file. Current visiting practitioners' practising certificates reviewed are current and include that of the general practitioner. Five staff files were reviewed (one clinical nurse manager, two caregivers, one activities coordinator and one cook). The staff files include employment documentation such as job descriptions, contracts and appointment documentation on file for permanent staff. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>The orientation programme includes a documented checklist relevant to the area of work, health and safety induction and infection control questionnaires. Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service. There is a two-yearly education plan in place that includes all required education as part of these standards, however, not all compulsory education has been completed. The owner/manager and clinical nurse manager attend external training including conferences, seminars and education sessions with the local district health board (DHB). The clinical nurse manager has completed training for interRAI assessment.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>appropriate coverage for the effective delivery of care and support. The owner/manager is on-site for at least four days a week and the clinical nurse manager works full time from Monday to Friday. The owner/manager is on call after hours for any operational issues and the clinical nurse manager is on call after hours for any clinical concerns with the assistance from senior caregivers. The rosters include a caregiver on the morning, afternoon and night shifts with a second caregiver for three to four hours on the morning and afternoon shifts. Interviews with caregivers and residents identify that staffing is adequate to meet the needs of residents.</p> <p>The prospective owner stated there will be no changes to staff who will transfer to the new owner on the date of settlement.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>There are resident files appropriate to the service type. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed with the designation.</p>
<p>Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment and care plan was completed on admission in files sampled. The service has an information pack available for residents/families/whānau at entry and it includes associated information such as the Code, advocacy, informed consent, and the complaints procedure. The five files reviewed included the admission agreement, which aligns with the ARC contract and exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The transfer/discharge/exit procedures include a transfer/discharge form and the completed form is placed on file. The clinical nurse manager interviewed stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There are documented policies and procedures for medication management. Medications are managed appropriately in line with required guidelines and legislation. Medications are checked in on delivery by the registered nurse (clinical nurse manager). Staff were observed administering medications during the lunch time medication round and followed correct procedures. Administration records are maintained. Interviews with staff and a review of staff files confirms that only staff who have been assessed as competent are responsible for medication management. Medication trolleys and cupboards are observed to be locked, with the keys being held by the staff member responsible for medications on the day.</p> <p>Medicines have been prescribed by the GP using a pharmacy generated medication chart. All charts include photo identification and any allergies identified. Three-monthly GP reviews are evident. Individually prescribed medications are used, and a robotics pack system utilised. There is one controlled drug locked safe and controlled drug logs are maintained with evidence of regular reconciliation sighted. There is a self-medicating resident's policy and procedure in place. There was one resident self-medicating inhalers on the day of audit. Residents have been assessed as competent to self-administer medications and the relevant form confirming this is signed by the GP. There is a dedicated medication fridge and daily monitoring of temperature is completed. Standing orders were in use and the practices comply with all contractual and legal requirements.</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>Residents are provided with a well-balanced diet which meets nutritional requirements. Meals are served plated direct from the kitchen to the dining room. The service has a four-week winter and summer menu reviewed by a dietitian. Residents interviewed are satisfied with the meals provided. Resident files reviewed show evidence of dietary profile documented on admission and sent through to the kitchen. This is updated as residents needs change, as evidenced in the folder of profiles reviewed. Special or modified diets are catered for. Individual food preference lists are sighted, and any allergies identified. The service</p>

		employs a chef who is supported by a weekend cook and care staff. Kitchen staff have required food safety qualifications. The kitchen is well stocked, clean and tidy. Fridge and freezer temperatures are recorded, and items are dated. Fresh fruit and vegetables and other food stuffs are stored appropriately.
<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	The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to potential residents is recorded and communicated to the potential resident/family. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. Assessments are reviewed at least six-monthly. Additional risk assessments for management of behaviour, wound care and nutrition were appropriately completed according to need. The clinical nurse manager has completed interRAI training and the assessment tool was evident in resident files. All resident's files evidenced a current interRAI assessment. Risk assessments completed were reflected in the care plans reviewed.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Interventions included support for current needs. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. Care plans reviewed had been evaluated for identified issues and were completed six-monthly, or as condition changed. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Families interviewed confirmed their involvement in the care planning process. Staff members reported they are informed about changes in the care plans. Integration of records and

		monitoring documents are well managed.
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Care plans are current, and interventions reflect the assessments conducted and the identified requirements of the residents. Interviews with care staff confirmed involvement of families in the care planning process. Caregivers and the clinical nurse manager interviewed, stated there is adequate equipment provided including continence and wound care supplies. Visual inspection confirmed that continence products were available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice was available as needed and this could be described. There were no wounds on the day of audit. Files evidenced that a wound assessment, wound management plan and evaluation had occurred as per policy and that all required documents were fully completed. Monitoring occurs for weight, vital signs, blood glucose and challenging behaviour. Short term care plans are available for use for changes in health status.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>	FA	<p>The activities coordinator works 16 hours a week, over three days. The activity programme is planned monthly and displayed in each resident's room. Activities planned for the day are displayed on noticeboards around the rest home. An activity plan is developed for each individual resident based on assessed needs and a complete history of past and present interests, career, family etc. on admission. Activity plans were reviewed six-monthly in files sampled. Activity progress notes are maintained. The activities coordinator interviewed explained the variety of the programme and the inclusion of exercise activities. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. Community groups are invited to participate in the programme. The service uses taxi vans for resident outings. Resident meetings provide a forum for feedback relating to activities. Residents interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plan reviews are signed as completed six-monthly by an RN and were updated as changes were noted in care requirements in files sampled. Care plan evaluations stated the degree of achievement of goals and interventions in all files sampled. These have been completed six monthly or sooner when there is a change in condition or care requirements. Evaluations document progress toward goals. The files reviewed included examples where changes in health status had been documented and followed up. Short-term care plans for short-term needs were evaluated and either resolved or added to the care plan as an ongoing problem. General practitioners review residents three-monthly or when requested if issues arise or health status changes. General practitioner interviewed stated that the communication from the service is appropriate and in a timely fashion. The family are notified of GP visits and three-monthly reviews by phone call and if unable to attend, they are informed of all the changes. Progress notes are updated daily or as health changes.</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>	<p>FA</p>	<p>The service facilitates access to other medical and non-medical services (eg, diabetic services, ear clinics, physiotherapist and mental health services for older people). Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted. Residents' interviewed reported they are involved as appropriate when referral to another service occurs.</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>	<p>FA</p>	<p>Chemicals are stored securely. Chemicals are clearly labelled with manufacturer labels and safety datasheets are available. Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons appropriately. The cleaner demonstrated knowledge of handling waste and chemicals. Safe chemical handling training has been provided.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness, which expires</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>on 21 February 2018. Hot water temperatures are checked monthly. Medical equipment and electrical appliances have been tested, tagged, and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. There are stairs and a lift to the upper floor. The service identifies planned annual maintenance and hazard identification forms for areas that require maintenance. There are external areas off the lounge and dining areas. The upper deck has an umbrella for shade. There is access to garden areas. Residents interviewed confirmed the environment was suitable to meet their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>All resident rooms in Glenhaven Rest home are occupied as single rooms. There are sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Residents interviewed stated their privacy and dignity is maintained while attending to their personal cares and hygiene. The communal toilets are well signed and identifiable and include appropriate locks. Communal bathrooms are available on both ground and upper floors.</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>	<p>FA</p>	<p>The resident rooms are of sufficient size to meet the resident's assessed needs. There are six double sized rooms available for couples but currently used as single rooms. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient area to allow cares to take place. The bedrooms were observed to be personalised. Residents and family members interviewed confirmed they were happy with their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining</p>	<p>FA</p>	<p>There is a large lounge and separate dining room, and one smaller lounge available in the upper floor. All areas are easily accessible for the residents. Residents interviewed reported they are able to move around the facility and staff assisted them when required. Activities take place in</p>

needs.		either of the lounges or the dining room.
<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>All laundry, including residents' personal laundry, is undertaken on-site by the caregiving staff. The service has standing operating procedures in place for cleaning. There is a dedicated storage area for cleaning equipment and chemicals. The external chemical supplier provides a monthly report on the effectiveness of the cleaning and laundry equipment and chemical usage. Manufacturer's data safety charts are available. Staff attend infection control education and there is appropriate protective clothing available. During interview, residents confirmed they are happy with the laundry services provided. Staff interviewed confirm they always have enough linen to meet day-to-day needs.</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>	FA	<p>Emergency management policies and procedures implemented, guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. At least one staff member is on duty at all times with a current first aid certificate. Fire equipment is checked annually by an approved provider. The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation plan. A letter sighted from the New Zealand Fire Service (2004) confirms the approved evacuation scheme. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service.</p> <p>Emergency supplies include sufficient water stored to ensure for three litres per day for three days per resident and enough food for three days. There is a civil defence kit and pandemic/outbreak supplies in the facility that are checked four-monthly. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking. Emergency education and training for staff includes six-monthly fire evacuations, the last fire evacuation drill occurred on 13 October 2017. Appropriate security systems are in place. There are security cameras that monitor the entrances. Staff and residents interviewed confirmed they feel safe at all times. Call bells are located in all resident areas. Resident interviews</p>

		confirm call bells were answered in an acceptable timeframe.
<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	All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable.
<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	Glenhaven Rest home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical nurse manager is the designated infection control coordinator. The clinical nurse manager confirmed that a surveillance programme is maintained and reviewed annually. Surveillance data is sighted and includes infection details related to clinical files sampled.
<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	The clinical nurse manager at Glenhaven Rest home is the infection control coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising the management team and care staff) has good external support from the nurse gerontologist, public health, healthcare help and the IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<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	There is infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by

are practical, safe, and appropriate/suitable for the type of service provided.		an external provider and have been reviewed and updated annually.
<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	Education has been provided to staff around infection control and is also included in the orientation process. Training sessions are documented, and attendance records completed. Minutes of staff/quality meetings sighted include discussions related to infection control practices. The infection control coordinator has had training around infection control specific to the role and the certificate is displayed in the infection control manual. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
<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	Infection surveillance is an integral part of the infection control programme and is described in Glenhaven Rest home's infection control manual. The infection control coordinator confirms a surveillance programme is maintained. Surveillance of all infections are entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff/quality meetings. Monthly analysis is completed and reported at monthly staff/quality meetings. Benchmarking data against other facilities was sighted. If there is an emergent issue, it is acted upon in a timely manner. An outbreak in August 2017 was appropriately managed and reported.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	Glenhaven Rest home has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were no residents on restraints or enablers. The restraint coordinator (clinical nurse manager) confirmed that the service promotes a restraint-free environment. Restraint education is included in the two-yearly training programme and last occurred in May 2017.



## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	There is a two-yearly education plan in place that includes all required education as part of these standards. Not all compulsory education had been completed in the two-yearly education plan.	Education not completed within the last two years includes abuse/neglect, complaints/open disclosure, pain management, end of life /death, spirituality/counselling, nutrition/hydration and the aging process.	<p>Ensure staff attend compulsory training as scheduled.</p> <p>90 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.