

Anglican-Methodist South Canterbury Glenwood HomeTrust Board - Glenwood Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Anglican-Methodist South Canterbury Glenwood Home Trust Board
Premises audited:	Glenwood Home
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 October 2017 End date: 5 October 2017
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:	40



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

The Anglican-Methodist South Canterbury Glenwood Home Trust Board owns and operates Glenwood Home. Glenwood Home provides rest home and hospital level of care for up to 42 residents. There were 40 residents at Glenwood Home on the day of audit.

This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The facility manager is a speech language therapist with significant health management experience and works full time. She has been in the position for 18 months. She is supported by a clinical manager with considerable experience in aged care, who has been in the role for two and a half years.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided at Glenwood.

Three of the three shortfalls identified as part of the previous partial provisional audit have been addressed. These were around recruitment of staff, orientation of staff and additional training for staff around where caring for residents with a higher level of need would be required.

The previous certification audit did not identify any areas requiring improvement.

This audit has identified one area requiring improvement around documenting indication for use for 'as required' medications.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is a business plan with goals for the service that has been regularly reviewed. Glenwood Home has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work

practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

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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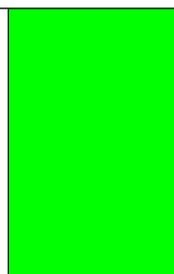
There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	15	0	1	0	0	0
Criteria	0	38	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<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 facility manager using a complaints' register. There have been three complaints made in 2017 and five in 2016. All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents (four rest home and three hospital) and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The facility manager and clinical manager confirmed family are kept informed. Relatives (two hospital and one rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident</p>

conducive to effective communication.		should they wish to do so. There is access to an interpreter service as required.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The Anglican-Methodist South Canterbury Glenwood Home Trust Board owns and operates Glenwood Home. The service provides care for up to 42 residents (including 29 dual-purpose beds and 13 rest home beds). On the day of audit, there were 23 rest home residents (including one on an independent funding contract) and 17 hospital care residents (including one on an end of life contract). All other residents were under the age-related residential care services agreement.</p> <p>The service has a business plan, which is reviewed annually. The business plan identifies the purpose, values and scope of the business and the inclusion of adding hospital services. The service has quality goals, which have been reviewed regularly. The facility manager has significant experience in health management and has been in the role at Glenwood Home for 18 months. The manager is supported by an experienced clinical manager (registered nurse), with a background in aged care.</p> <p>The manager has completed at least eight hours of professional development.</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>	FA	<p>Glenwood Home has a well-established and comprehensive quality and risk programme.</p> <p>There are annual reviews documented for activities, health and safety, risk management, complaints, infection control and medications. This information has been used to formulate ongoing business and quality plans.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (three healthcare assistants, one registered nurse, one cook, one diversional therapist and the head cook) confirmed they are made aware of any new/reviewed policies. There are sufficient clinical policies/procedures to support hospital level care.</p> <p>The Glenwood Home board meet monthly and the facility manager attends the meeting and provides a monthly report. The quality plan is reviewed for effectiveness each meeting. Board members tour the facility bi-monthly.</p> <p>Three-monthly quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs.</p> <p>Facility meetings held include: quality and health and safety, full staff meetings, kitchen meetings, resident and relative meetings, diversional therapy and cleaners meetings. Meetings minutes sighted evidence there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results, trends and</p>

		<p>corrective actions.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. A three-monthly summary of internal audit outcomes is provided to the quality meetings for discussion. Corrective actions are developed, implemented and signed off.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</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>	FA	<p>The service collects incident and accident data on forms and enters them into an electronic register. The system provides reports monthly, which are discussed at the monthly staff meetings and the three-monthly quality and health and safety meetings.</p> <p>Sixteen incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The clinical manager collects incident forms, investigates and reviews and implements corrective actions as required.</p> <p>The facility manager interviewed could describe situations that would require reporting to relevant authorities. The service has reported four fractures to the Ministry of Health.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>There are human resources policies to support recruitment practices. The register of RN's practising certificates and allied health professionals is current. Six staff files were reviewed (two RNs, two healthcare assistants, one diversional therapist and one cook). All files contained relevant employment documentation including current performance appraisals and completed orientations. Current practising certificates were sighted for the registered nurses. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care. These previously identified shortfalls have been addressed.</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is a comprehensive annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. The programme has been updated to include caring for residents with a higher level of care including but not limited to: manual handling and turning residents, pressure injury prevention, end of life, continence and care of catheters. This previously identified shortfall has been addressed. Six of the eight RNs have completed interRAI training. Clinical staff complete competencies relevant to their role. The RNs and clinical manager have completed syringe driver training and have access to external training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The human resources policy determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. An RN is available on call weekends and after hours and can contact the clinical manager as required for clinical concerns. The facility manager (non-clinical) and the clinical manager/RN are on duty during the day Monday to Friday. There is a RN on duty 24 hours. There are five healthcare assistants on both morning and afternoon shifts and two on night shift.</p> <p>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RN, and clinical and facility manager who respond quickly to after-hour calls.</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>PA Low</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Medication orders do not always include indications for use of 'as needed' medicines. Short-life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Administration sheets sampled were appropriately signed. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. Two residents self-administer medicines and have current competency assessments around this. They have access to secure storage in their rooms. Staff check each shift that these residents have safely self-administered their medications and record this on the medication administration sheet.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>There is a fully equipped commercial kitchen, which is located centrally in the facility. The majority of food is prepared and cooked on-site. There are three cooks that are rostered over a 2-week roster period (main cook and kitchen hand. Then a tea cook later in the day). The menu is a 4-week rotating menu. The main meal of the day is served at lunchtime. All kitchen staff have completed food safety training. The menu has been approved by a dietitian. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served directly from the kitchen to residents in the dining room or to their rooms as required. A tray service is available if required by residents. All food in the freezer and fridge was labelled and dated. Food procurement occurs from commercial operators. Kitchen waste is collected by commercial operators. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for and currently the kitchen is catering for a resident who prefers gluten-free meals. Alternative meals can be accommodated if needed. Residents' weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented.</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>	FA	<p>Service delivery is guided by the resident's plan of care. The interRAI assessment process informs the development of the care plan. Care plans sampled were goal orientated and reviewed at six monthly intervals (for long-term residents). The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.</p> <p>The end of life resident file sampled had a plan of care with all appropriate needs documented. The independent funding contract resident had regular input from the mental health team and a relapse prevention plan documented.</p> <p>There were seven residents with nine wounds at the time of the audit. One resident had a grade 1 pressure injury. Assessments, management plans and documented reviews were in place for all wounds.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available two days during the week to assist with mobility assessments and the exercise programme.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as</p>	FA	<p>There are two staff employed (one a diversional therapist and one a diversional therapist in training) who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for seven hours per day, seven days per week.</p>

<p>part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>Group activities are provided in the large communal dining room, in seating areas and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance.</p> <p>Individual activities are provided in resident's rooms or wherever applicable.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and a copy of the programme is available in the lounge, on noticeboards and in each resident room. The group programme includes residents being involved within the community with social clubs, churches and schools.</p> <p>The DT interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>Glenwood Home has its own van for transportation. The DT drives the van and has a current first aid certificate. Residents interviewed described weekly van outings, musical entertainment and attendance at a variety of community events.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. Two residents were new to the service and had not yet required care plan evaluations. Care plan reviews are signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate,</p>	<p>FA</p>	<p>A current building warrant of fitness is prominently displayed.</p>

accessible physical environment and facilities that are fit for their purpose.		
<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	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	PA Low	<p>GPs prescribe all medications. Medication charts included the date started for all medications and stopped where relevant. All charts sampled were legible and had been reviewed three-monthly. Indications for use for ‘as required’ medications were not always documented.</p>	<p>Three of ten medication charts sampled did not have indications for use documented for ‘as required’ medications.</p>	<p>Ensure that all ‘as required’ medications have the indication for use documented by the prescriber.</p> <p>60 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.