

# Heritage Lifecare (BPA) Limited - Glengarry Rest Home & Hospital

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## 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 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:

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|---|---|---------------------------|
| <b>Legal entity:</b>  | Heritage Lifecare (BPA) Limited   |                           |
| <b>Premises audited:</b>  | Glengarry Rest Home & Hospital  |                           |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |                           |
| <b>Dates of audit:</b>  | Start date: 15 January 2018   | End date: 16 January 2018 |
| <b>Proposed changes to current services (if any):</b>   | None  |                           |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 39  |                           |

# Executive summary of the audit

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## 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

## General overview of the audit

Glengarry Rest Home and Hospital provides rest home, hospital and dementia level care for up to 41 residents. The service is currently operated by Bupa New Zealand.

The facility is managed by a care home manager and a clinical manager. Residents and families spoke positively about the care provided.

This provisional audit was requested by Heritage Lifecare Limited and was conducted against the Health and Disability Services Standards and the service's contracts with the Hawkes Bay District Health Board. The audit process included review of policies and

procedures, review of residents' and staff files, observations and interviews with residents, family/whanau, management, staff, contracted allied health providers and a general practitioner.

This audit has resulted in one area of improvement relating to the Infection Control programme, which has not been reviewed within the last 12 months. Improvements have been made to those areas identified in the current provider's last onsite audit and these are now closed.

## **Consumer rights**

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Maori is guided by a comprehensive Māori health plan and related policies.

There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

A complaints register is maintained with complaints resolved promptly and effectively. The care home manager is responsible for the management of complaints. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

## **Organisational management**

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using an integrated (electronic; hard copy) file.

## **Continuum of service delivery**

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Evidence verified residents of Glengarry Rest Home and Hospital have their needs assessed on admission by the multidisciplinary team, within the required timeframes. Shift handovers and the care manager's report guides continuity of care.

Care plans reflect the commitment of Glengarry Rest Home and Hospital to provide individualised care, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any recent problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme is overseen by a diversional therapist and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by either registered nurses, enrolled nurses, or care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## **Safe and appropriate environment**

The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## **Restraint minimisation and safe practice**

The organisation has implemented policies and procedures that support the minimisation of restraint. The facility now operates with a restraint free environment.

Two residents used enablers at the time of audit. These were used voluntarily for their safety and in response to individual requests. Staff demonstrated a sound knowledge and understanding of the enabler processes.

## **Infection prevention and control**

The infection prevention and control programme, led by an experienced and appropriately trained infection control officer, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the organisations Infection control co-ordinator, the Hawkes Bay District Health Board (HBDHB) or the clinical nurse specialist (nurse practitioner intern). The programme has not been reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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                  | 1  | 0                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 92                  | 1  | 0                                    | 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   |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>  | FA                | <p>Glengarry Rest Home and Hospital has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed, and internal audits verify staff understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of</p>   |



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|  |    | <p>attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur. All resident files reviewed in the secure unit have an enduring power of attorney (EPOA) in place.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</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>       | FA | <p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have a support person. The residents of Glengarry have their own independent advocate who runs the residents meeting. Interview with the advocate verifies the facilitation by the service in enabling residents to access the services of the independent advocate and the advocacy service. The advocate is complimentary of management's prompt response to any resident's concerns.</p> <p>Staff were aware of how to access the Advocacy Service.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | FA | <p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>  |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood,</p>  | FA | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaints process is provided to</p>   |

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| <p>respected, and upheld.</p>   |           | <p>residents and families on admission. Staff members understood their responsibilities for supporting the complaints process. Residents and whanau interviewed knew how to raise complaints and make their concerns known.</p> <p>The complaints register reviewed showed that five complaints had been received during 2017, four of these from residents in the aged care facility and one from a person using day programme services. Actions taken, through to an agreed resolution, are documented and completed within the timeframes of the Code</p> <p>Action plans show required follow up and improvements have been made where needed.</p> <p>The care home manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery<br/>Consumers are informed of their rights.</p>  | <p>FA</p> | <p>Residents and family interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. Training on the Code and the Advocacy service is provided yearly to residents by the advocacy service. The Code is displayed in communal areas together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>The prospective purchaser is an experienced aged care sector provider. Existing clinical staff are transitioning to the new provider following the sale and they have a good understanding of the code as part of their existing role.</p>   |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect<br/>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and</p> | <p>FA</p> | <p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring</p>   |

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| <p>independence.</p>   |           | <p>resident information is held securely and privately, exchanging verbal information and discussion with families and the general practitioner (GP). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff and is then provided on an annual basis (June 2017), as confirmed by staff interviews and training logs.</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>Most residents in Glengarry Rest Home and Hospital at the time of audit identify as Māori, as do many staff. The facilities are located within a predominantly Māori community well equipped to support residents to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori partnership plan developed with input from a range of cultural advisers. A Māori provider attends Glengarry twice weekly and presents a 'sit and be fit' programme, in addition to organising monthly meetings for the residents with a Kaumatua at one of the Maraes.</p> <p>The menu incorporates traditional Māori cooking regimes. Resident's cultural and spiritual beliefs and practices are individually recognised and addressed in each resident's care plan. Karakia occurs before each residents' meeting commences.</p>   |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>   | <p>FA</p> | <p>Residents verified that they were consulted on their individual culture,</p>  |

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| <p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> |           | <p>values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>   |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>                 | <p>FA</p> | <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. It is completed at commencement of employment. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>                                 |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>   | <p>FA</p> | <p>The organisation offers a wide range of on and off-site training and support for its managers and staff. The clinical manager (CM) has just completed a comprehensive leadership course, and the diversional therapist described attendance at the three-monthly meetings for activities personnel to promote a diverse and collaborative approach to the organisations activity programmes.</p> <p>The service encourages and promotes good practice through evidence based policies, in house training, the organisations external training, input from external specialist services and allied health professionals, for example, hospice/palliative care team, speech language therapist, clinical nurse specialist, district nurses, community Māori health providers, mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate</p> |

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|  |           | <p>medical intervention when required and were responsive to medical requests.</p> <p>Eleven of seventeen caregivers have a qualification in caring for residents with dementia, three are in training and three more are enrolled. The cook and diversional therapist are trained in dementia. All caregivers have level two or three qualifications in care of the older adult. Two RNs have post graduate qualifications in infection control and all RNs are syringe driver competent.</p> <p>Staff reported they receive management support for education to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included a commitment to an environment of no restraint, ongoing attention to a reduction in the number of falls, a commitment to ensuring residents receive care that attends to residents individualised needs and maintaining resident's participation and active involvement in the community.</p>   |
| <p><b>Standard 1.1.9: Communication</b></p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Residents and family members interviewed verified they had been informed of a prospective purchaser, and were comfortable the care home manager (CHM) would address any concerns they had. A meeting was arranged for residents and families to meet with the prospective purchaser within the next week.</p> <p>Interpreter services can be accessed via the DHB when required. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p> |

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| <p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>The facility has a quality plan which includes the organisation's purpose, values, scope and direction. These are reviewed annually with the quality plan. Monthly reports to the operations manager provide adequate information to monitor performance is reported including financial performance, occupancy, wage analysis staffing and any issues.</p> <p>The service is managed by a care home manager who holds relevant qualifications and has been in the role for five years. Responsibilities and accountabilities are defined in a job description and an individual employment agreement. The care home manager maintains her knowledge of the sector, regulatory and reporting requirements and currency through regular management forums with the current provider and management development training. She attends multi-disciplinary meetings at the Wairoa Hospital and is part of local clinical governance group. The manager has attended more than eight hours of professional development relating to management of an aged care facility.</p> <p>The service holds contracts with Hawkes Bay District Health Board (HBDHB) for Aged Related Residential Care, Aged Related Hospital Services and the Engage contract for a service to assist with the transition from hospital to home. They also hold a contract with the Ministry of Health (MOH) for younger people with disabilities.</p> <p>On the first day of the audit there were 39 residents at Glengarry. There is a nine bed dementia unit which was fully occupied on the days of this audit. In the rest home and hospital wing all 32 beds are certified as dual purpose. On the days of this audit there were 17 residents receiving rest home level care and 13 residents receiving hospital level care. On the days of audit there were three residents funded under the MOH contract. One person was receiving rest home care and the other two were receiving hospital level care.</p> <p>The new provider is Heritage Lifecare Ltd (HLL) which is an established New Zealand aged care provider, currently operating more than 1100 beds in the sector. An organisational structure document sighted details the reporting lines to the board currently in place (as at 30 November 2017). Glengarry is one of twelve proposed facility acquisitions across the country. As of 30 January 2018 HLL has set up a new company to</p> |

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|  |           | <p>acquire and operate this group of new facilities. This company is Heritage Lifecare (BPA) Ltd. However for ease of reference the new provider is referred to as Heritage Lifecare Limited (HLL) throughout this report.</p> <p>There is a transition plan which is led by an experienced and well-qualified project team who are specifically focussing on the integration of new facilities into the HHL group. This includes provision of infrastructure support such as information technology capability including hardware and software.</p> <p>It is expected that the senior team will remain in place at each facility and that existing staff will transfer to the new provider. The prospective purchaser has notified the District Health Board prior to the provisional audit being undertaken.</p> |
| <p><b>Standard 1.2.2: Service Management</b></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>When the care home manager is absent for up to two weeks, the clinical manager carries out all the required duties under delegated authority. She is supported by the operations manager. During longer absences a temporary manager is appointed to manage the facility. Staff reported the current arrangements work well.</p> <p>The prospective provider is not planning any staffing changes. Existing cover arrangements for the day to day operations will remain in place, with access to regional operations managers.</p>   |
| <p><b>Standard 1.2.3: Quality And Risk Management Systems</b></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>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of accidents and incidents, compliments and complaints, internal audit activities, a regular resident satisfaction survey, infections, falls, maintaining the restraint free environment and use of enablers.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings, quality meetings, infection control and health and safety meetings. Staff reported their involvement in this range of meetings and quality and risk management activities in different ways. They received updates on audit activities and any findings. Relevant</p>   |

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|   |           | <p>corrective actions are developed and implemented to address any shortfalls and examples were seen, with follow up in the meeting minutes.</p> <p>Resident satisfaction surveys are completed annually and support the feedback the facility receives from residents during their monthly meetings.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process and provide guidance to meet the requirements of the contracts held and services provided.</p> <p>Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. (One exception is noted against Standard 3.1)</p> <p>The care home manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Evidence of this was reviewed with the manager in their meeting minutes and at interview.</p> <p>During the transition phase, HLL policies and procedures will be introduced. HLL has a generic annual quality plan in place which outlines goals and objectives for the coming year. Each site personalises this to their own facility. The plan includes Internal audits and improvement activities and projects. The HLL quality plan will be introduced to managers at the proposed regional study days to occur during the transition period. Reporting against the quality plan occurs monthly through the operational management structure.</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>Staff document adverse and near miss events through an electronic system (since August 2017). A review of this system showed that sufficient information is reported and recorded and incidents are investigated, action plans developed and actions followed-up in a timely manner.</p> <p>Adverse event data is collated, analysed and reported to the Bupa</p>  |



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|   |           | <p>operations manager in the manager's monthly reports.</p> <p>The care home manager described essential notification reporting requirements. These are done by Bupa centrally after the facility reports through the electronic accident/ incident report system. The manager is aware of essential notifications required in 2017 due to a pressure injury (one) and residents who had been able to leave the dementia unit briefly (two).</p> <p>The prospective owner is aware of all current health and safety legislative requirements and the need to comply with these. They have appropriate systems for the reporting of essential notifications. The senior quality and compliance manager was able to verbalise knowledge and understanding of actions to meet legislative and contractual requirements.</p>  |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation, ongoing education and annual performance reviews for all staff.</p> <p>Continuing education is planned on an annual basis and includes mandatory training requirements and competencies for all staff. At the time of this audit all caregivers have either a level two or level three New Zealand Qualifications Authority (NZQA) qualification. Eleven of seventeen care staff, the Diversional Therapist and one of the housekeeping staff members, have completed the required Dementia unit standards. Another five of the remaining six care staff are enrolled in these units standards and three have commenced study. The two who have not yet commenced study are new staff, as is the only care staff member who has not yet enrolled. (This staff member has been</p> |

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|   |           | <p>employed by the facility but has not yet commenced work.)</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. In March 2017 the facility was recognised by HBDHB as being up to date with their interRAI assessments. The facility remains up to date with their assessments. Records reviewed during this audit demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>Training records also include the requirements for hospital medical care. All registered nursing staff have annual syringe driver competency and other relevant competencies. These were current at the time of this audit.</p> <p>An area for improvement identified at the facility's last onsite audit noted that there was inadequate attendance at in-service training. Effort has been made to increase attendance over the past 18 months and has been noted in meeting minutes each month. Attendance has varied from 59% average in early 2017 to 65% average at the end of 2017. However attendance at individual sessions by the end of 2017 was from 76% - 96% of staff attendance at general in-services, and 100% completion of mandatory competencies. Meeting minutes record the focus on training attendance to continue into 2018.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>Observations and review of a fortnightly roster confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital. The rostered staffing complement meets the contract requirements for rest home, hospital and</p>   |

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|   |    | <p>dementia services.</p> <p>The prospective owner intends to maintain the current staffing levels and skill mix. HLL has a documented policy based on the Guidelines for safe staffing level and indicators. The representative for HLL was interviewed and confirmed an understanding of the required skill mix to ensure rest home and dementia care residents needs are met. The organisation already provides the range of levels of care (geriatric/medical, dementia, rest home and psychogeriatric services) and recognises the competencies and contractual obligations to be met when delivering these services.</p>  |
| <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, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held off site for the required period before being destroyed. No personal or private resident information was on public display during the audit.</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>Residents are admitted to Glengarry Rest Home and Hospital when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service, as requiring services provided by Glengarry. Specialist referral of residents in the secure unit is sighted, and enduring power of attorneys are sighted in the files reviewed of these residents. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the CHM or the CM. They are also provided with written information about the service and the admission process.</p>   |

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|   |    | Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Nine files reviewed (5 x rest home [from that 2 x YPD, 1 x respite, 2 x rest home], 2 x secure unit and 2 x hospital) contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.   |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.               | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort and a phone call as appropriate. The CHM attends regular multidisciplinary meetings at the DHB, discussion includes resident transition, discharge and admission. The service uses the HBDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management<br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy at Glengarry Rest Home and Hospital is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.<br><br>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are assessed as competent to perform the function they manage.<br><br>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by  |

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|   |    | <p>dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit, however appropriate processes are in place if any resident's request to do so.</p> <p>Interview with the CHN, CM and care staff identified the service is committed to reducing the amount of pro re nata (PRN) anti-psychotic medication used by residents in the secure unit. Preferring to look at managing behaviours using other strategies. Observation verified residents as very settled. A review of PRN anti-psychotic medication use in the secure unit identified no usage in the past month.</p> <p>Medication errors are reported to the RN and CM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified after a review of the process initiated following a dispensing error by the pharmacy.</p> <p>Standing orders are used by two of the three practices servicing Glengarry, and these orders meet guidelines. They are due to expire at the end of the month at which time standing orders will no longer be used.</p> |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management | FA | The food service is provided on site by a cook and is in line with  |

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| <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> |           | <p>recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has remained unchanged since a review by a qualified dietitian in 2016. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for elevated risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A food control plan has been registered with the Ministry of Primary Industries and expires 22-September-2018.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Residents in the secure unit have access to food at any time. A small kitchenette in the unit contains a wide array of food items, however the kitchen can be accessed from the unit and interviews verify food can be accessed at any time. Residents at meal times were observed to be settled, seated comfortably at the tables, eating well and expressed satisfaction with the meal. Meal times in the unit are "protected" with the focus being on the meal. Medications are not dispensed during meal times. Residents' weights are stable.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p>  | <p>FA</p> | <p>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised</p>  |

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| <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> |           | <p>to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau. Examples of this occurring were discussed with the CM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>   |
| <p>Standard 1.3.4: Assessment<br/>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>                              | <p>FA</p> | <p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of three trained interRAI assessors on site.</p>   |
| <p>Standard 1.3.5: Planning<br/>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>                      | <p>FA</p> | <p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed. All residents have a "map of life", identifying past lifestyle patterns, interests, jobs and family. In addition, there is a "my way, my day plan" that describes the individualised routines and needs of the resident, and how these are to be met.</p> <p>Residents in the secure unit, in addition to the above, have a dementia care plan which identifies things that may upset the resident, and associated triggers, plus the things that calm the resident. While episodes of challenging behaviour are monitored, events are few. Continuity of staff evidences staff who are well tuned to the needs to the resident. Input from the visiting psycho geriatrician three monthly is evident in resident's notes with assistance accessible from the community mental health nurse, the CM or the organisation's dementia care advisor.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written,</p> |

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|   |    | informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.  |
| <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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. A previous corrective action requiring the appropriate monitoring to be in place for residents using enablers and residents with a bang to the head, has been addressed. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP verified that medical input is sought in a timely manner and that medical orders are followed. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' 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 the service.</p> | FA | <p>The activities programme is provided by a qualified diversional therapist, six days a week.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-monthly care plan review and multidisciplinary review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included visits to the local hairdresser, attendance at the Mayor's morning teas, museum functions, morning tea in the local cafes, involvement in activities organised by the Māori health provider at a local Marae, monthly Kaumatua days and weekly outings. The activities programme is discussed at the residents' meetings and</p> |



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|  |           | <p>indicated residents' input is sought and responded to.</p> <p>A holistic twenty four-hour approach to activities is observed in the secure unit. Assessment on admission includes "map of life" and includes all aspects of the resident's life. The plan of care and activities focusses on "my way, my day" and specifically details the resident's daily lifestyle patterns and routines to be followed, including the resident's interests. Activities in the secure unit, focus on resident's abilities. The reading of a newspaper, capturing the events of the 1970's is observed to inspire memories, discussion and a request for music of the time. A resident is observed assisting with dishes and chores, while others attend to the garden. The environment is relaxed and peaceful. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</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>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed, and includes photographs as evidence.</p> <p>Comprehensive evaluation is sighted on the use of anti-psychotic medications, with a monthly review occurring to determine effectiveness and record any untoward effects. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> |

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| <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>Residents are supported to access or seek referral to other health and/or disability service providers. The service has access to a clinical nurse specialist (CNS) who is an intern nurse practitioner who works across Wairoa Hospital (HBDHB) and the DHB health centre. Although the service has a main medical provider, residents may choose to use another medical practitioner. The facility can access the services of the CNS, for clients from other health centres and the CNS will liaise with the clients GP.</p> <p>If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary.</p> <p>An external company is contracted to supply and manage all cleaning and laundry products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and in the laundry and cleaner's storage areas. Staff interviewed understood the requirements of their roles and knew what to do should any chemical spill/event occur.</p> <p>Protective clothing and equipment are available. Staff were observed using this equipment as needed and confirmed that sufficient supplies are available.</p>  |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>   | <p>FA</p> | <p>A current building warrant of fitness (expiry date 1 June 2018) is publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical</p>  |

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| <p>environment and facilities that are fit for their purpose.</p>   |           | <p>environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current, and supporting documentation was reviewed. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted.</p> <p>Residents were observed moving around the facility either independently or using mobility equipment. If assistance is needed there is sufficient room for staff members to move residents using their mobility equipment.</p> <p>The facility is on one level with smooth floor surfaces, handrails throughout and flat access in and outdoors. External areas are safely maintained and are appropriate to the resident groups and setting. The dementia unit is secure and appropriate to the needs of this group, with an attractive and accessible garden</p> <p>In the residents meetings and annual satisfaction surveys, residents report satisfaction with the environment.</p> <p>HLL are not currently planning any changes to the facility.</p> |
| <p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b><br/>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>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes one ensuite bathroom in a bedroom, and two staff toilets throughout the facility.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>   |
| <p><b>Standard 1.4.4: Personal Space/Bed Areas</b><br/>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>   | <p>FA</p> | <p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>Staff and residents reported the adequacy of bedrooms.</p>  |

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| <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 needs.</p> | <p>FA</p> | <p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</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>Laundry is undertaken on site in a dedicated laundry. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Feedback from residents and family members confirms satisfaction with the laundry services.</p> <p>There is a designated cleaning team who have access to appropriate equipment and cleaning products. Cleaning chemicals were stored in a lockable cupboard when not in use and were in appropriately labelled containers on the cleaner's trolley.</p> <p>Laundry and cleaning staff attend all relevant training, as confirmed their knowledge of cleaning and laundry processes during interviews. Attendance was confirmed during review of cleaning staff training records.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme. In April 2017 the internal cleanliness audit had a 79% result. This audit was repeated quarterly and each team increased until November when the cleanliness audit was 94%. The laundry audit is scheduled to be completed each January. When it was completed in 2017 the result was 96%.</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>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence plans direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. Glengarry is also part of local networks involving the Wairoa hospital and town council. There are regular meetings and activities which are included in their emergency plan. All staff complete an annual civil</p>   |

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|  |           | <p>defence competency and these were current on the staff files reviewed.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 21 May 2012. A trial evacuation takes place six-monthly. The most recent evacuation was on 8 September 2017 and was observed by the local Fire Service. The orientation programme includes fire evacuation and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>There are adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, communication equipment and a gas BBQ were sighted and meet the requirements for the number of residents and staff at the facility. Water storage tanks are located around the complex. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis within the suite of internal audits. During discussion with residents at their monthly meetings in 2017, residents requested that some call bell leads be made available in addition to already installed call point in the lounge. These were provided to the satisfaction, and appreciation, of residents.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the RN on night duty regularly checks doors throughout the night.</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> | <p>FA</p> | <p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows. There is one bedroom which is internally situated and has a window which opens onto an internal courtyard. The occupant has been given the choice of other rooms and / or having a skylight installed. The care home manager reported that they are happy with their bedroom as it is and do not wish to move.</p> <p>Heating in bedrooms is provided by wall mounted electric heaters and heat pumps in the communal areas. On the days of the audit all areas were well ventilated, and residents and families confirm through the facilities are maintained at a comfortable temperature throughout the year.</p>  |

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| <p><b>Standard 3.1: Infection control management</b></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> | <p>PA<br/>Negligible</p> | <p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. The programme is developed by the organisations quality and risk team, with input from each facilities infection control officers (ICO), external advisors and the national health and safety co-ordinator. Infection control management is guided by a comprehensive and current infection control manual. The infection control policies have been reviewed in the past two years, however the programme has not been reviewed annually.</p> <p>The RN with input from the CM is the designated infection control nurse coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CHM and tabled at the monthly management/quality/staff meetings and two monthly infection control committee (ICC) meeting. Immediate concerns are managed daily and handed over at shift changes. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisations quality/risk manager receives a written report monthly and is immediately informed of any IPC concern.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p> |
| <p><b>Standard 3.2: Implementing the infection control programme</b></p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>                   | <p>FA</p>                | <p>The ICO has appropriate skills, knowledge and qualifications for the role, however has only been in this role since November 2017 and is being assisted by the CM. The ICO and CM have undertaken post graduate training in infection prevention and control and attended recent study days, as verified in training records sighted. Well-established local networks with the CNS at the DHB are available and expert advice. The ICO has access to residents' records and diagnostic results to ensure</p>   |

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|   |    | <p>timely treatment and resolution of any infections.</p> <p>The ICO and CM confirmed the availability of resources to support the programme and any outbreak of an infection.</p>  |
| <p><b>Standard 3.3: Policies and procedures</b></p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last two years and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>   |
| <p><b>Standard 3.4: Education</b></p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>  | FA | <p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICO or CM. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that a corrective action plan is put in place, and additional staff education has been provided in response. An example of this occurred when there was a recent increase in urinary tract infections in the secure unit.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather.</p> |
| <p><b>Standard 3.5: Surveillance</b></p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the</p>   | FA | <p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal,</p>   |

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| <p>infection control programme.</p>  |           | <p>eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICO and CM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers. Staff interviews verify knowledge of surveillance data.</p> <p>An unconfirmed norovirus outbreak in November 2016 involved nine residents and staff. Analysis and management of the outbreak identified comprehensive management of the outbreak. The outbreak was not confirmed as norovirus.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The facility maintains a no restraint environment.</p> <p>The clinical manager is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. She demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, two residents were using enablers, which were the least restrictive option and used voluntarily at their request. An assessment of risk and evaluation of ongoing need is conducted at three monthly intervals for the enablers. All documentation was up to date for both residents. (See also standard 1.3.6)</p> <p>HLL has policies and procedures in place to guide staff in the safe use of restraint and its minimisation as well as for the use of enablers. These policies are implemented across the HLL group and a small number of</p>   |



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|  |  | restraint devices are approved for use following assessment. |
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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)                                   |
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| <p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p> | <p>PA</p> <p>Negligible</p> | <p>The organisation has a clearly defined IPC programme, developed at organisational level by the quality and risk team. The policies are evidenced to have been reviewed in the last two years and compliance with the programmes implementation at Glengarry Rest Home and Hospital is sighted. There is no documentation to verify the programme has been reviewed annually. This finding is verified by interviews with the ICO, CM and documentation from the organisations quality management co-ordinator. The organisation has documented its commitment to reviewing the programme prior to the end of March 2018.</p> | <p>The infection control programme has not been reviewed within the last year.</p> | <p>To provide evidence the infection control programme is reviewed annually.</p> <p>180 days</p> |

## Specific results for criterion where a continuous improvement has been recorded

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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.

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| No data to display |
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End of the report.