# Grace Comfort Care Limited - Glenhaven Resthome

## Introduction

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

The audit has been conducted by 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Grace Comfort Care Limited

**Premises audited:** Glenhaven Resthome

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

**Dates of audit:** Start date: 22 November 2018 End date: 22 November 2018

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

**Total beds occupied across all premises included in the audit on the first day of the audit:** 18

# 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 |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Glenhaven Rest Home provides rest home level care for up to 24 residents. On the day of the audit there were 18 residents.

This certification audit was conducted against the relevant 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, staff and a general practitioner.

The facility manager is appropriately experienced and is supported by a clinical manager (registered nurse) who oversees the residents’ clinical cares. Quality systems are being implemented. Feedback from residents and families was very positive about the care and services provided.

This audit identified the service has fully attained all standards.

## 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. |

The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed in visible locations and in the entry to services information that is provided to residents and families. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family. Residents interviewed spoke positively about the care provided. Complaints processes are implemented, and complaints and concerns are managed. Staff training reinforces a sound understanding of residents’ rights.

## 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. |

The implemented quality and risk management system includes the management of complaints, implementation of an internal audit schedule, monitoring incidents and accidents, review of infections, and the review of health and safety systems.

Human resources policies are in place including a documented rationale for determining staffing levels and skill mixes. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there is sufficient staff on duty at all times.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrated service integration and are reviewed at least six-monthly. Resident files include medical notes by the contracted general practitioner (GP) and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Medication competent caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents were very satisfied with the meals.

## 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. |

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. There are sufficient numbers of showers/toilets. External areas are safe and well maintained with shade and seating available. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system. There is a civil defence kit and evidence of supplies in the event of an emergency in line with civil defence guidelines. There is a staff member on duty at all times with a current first aid certificate.

## 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. |

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

## Infection prevention and control

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| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the infection control coordinator who is responsible for the collation of infections and orientation and education for staff. There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

## 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 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)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Code of Health and Disability Services Consumers’ Rights (the Code) policy and procedure is implemented. Discussions with the facility manager, clinical manager/registered nurse (RN), two caregiver staff and one cook confirmed their familiarity with the Code. Interviews with eight residents and three family members confirmed that the services being provided are in line with the Code. Aspects of the Code are discussed at resident and staff meetings. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has in place a policy for informed consent. Completed resuscitation and general consent forms were evident in all five resident files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for entering rooms and personal care. Two of the five files reviewed had a designated enduring power of attorney. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with a copy of the Code and advocacy pamphlets on entry. Nationwide Health and Disability Advocacy service information is part of the admission pack. Interviews with the residents confirmed their understanding of the availability of advocacy services. Caregivers and the clinical manager interviewed were aware of the resident’s right to advocacy services and how to access the information. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy and family and friends are encouraged to visit the home and are not restricted to visiting times. Residents interviewed stated that they are supported and encouraged to remain involved in the community. During the audit, residents were observed freely coming and going from the facility. Community groups visit the home as part of the activities programme. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written, are maintained by the facility manager using a complaint’s register. There have been two complaints lodged in 2018 (year to date) that were reviewed. In each case, appropriate actions were taken within the required timeframes and to the satisfaction of the complainant. Residents and families interviewed advised that they are aware of the complaints’ procedure. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | There is a welcome information folder that includes information about the Code. Posters display the Code and leaflets are available. The service is able to provide information about the Code in different languages and/or in large print if requested. Written information is given to residents and/or next of kin/enduring power of attorney (EPOA) to read with the resident and discuss. There is opportunity to discuss this prior to entry and/or at admission with the resident, family or legal representative. The facility manager is available to discuss concerns or complaints with residents and families at any time. Residents interviewed stated they receive sufficient verbal and written information to be able to make informed choices on matters that affect them. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Staff interviewed were able to describe how they maintain resident privacy.  The education programme includes staff training on privacy/dignity and abuse and neglect. There have been no reported instances of abuse or neglect. Care staff interviewed stated they promote independence with daily activities where appropriate. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | There is a Māori health plan and ethnicity awareness policy and procedure. The policy includes references to other Māori providers available and interpreter services. The Māori health plan identifies the importance of whānau.  On the day of the audit there was one resident that identified as Māori. A comprehensive and personalised cultural assessment had been completed for this resident to provide direction for staff. This resident was interviewed and stated that her needs were being met by the service. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to maintain their spiritual needs with regular on-site church services and attending other community groups as desired. Staff attend two yearly cultural awareness training. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries are defined in job descriptions. Staff were observed to be professional within the culture of a family environment. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with caregivers could describe how they build a supportive relationship with each resident. Residents interviewed stated they are treated fairly and with respect. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The facility manager and clinical manager demonstrate a commitment to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. All residents and families interviewed spoke positively about the care provided. The service has implemented policies and procedures from a recognised aged care consultant to provide a good level of assurance that it is adhering to relevant standards. Staff interviewed had a sound understanding of the principles of aged care and stated that they feel supported by management. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Management promotes an open-door policy. Residents confirmed on interview that the staff and management are approachable and available. Information is provided in formats suitable for the resident and their family. Residents and family are informed prior to entry of the scope of services and any items that are not covered by the agreement. Communication with family members is recorded on the incident report forms and in the resident daily progress notes. Fifteen incident forms reviewed for 2018, confirmed that family were notified following a resident incident. Interpreters are available as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Glenhaven Rest Home can provide care for up to 24 residents requiring care at rest home level. On the day of audit there were 18 residents. All the residents were under the age-related residential care (ARRC) agreement.  The service has a strategic business plan (2017-2019) in place. The business plan includes a mission statement, values and goals. Business goals are reviewed three-monthly as per the quarterly service review.  Glenhaven Rest Home is owned by the spouse of the facility manager. He was not available during the audit. The owner and facility manager have owned five other aged care facilities over the past 10 years. Presently they only own and manage Glenhaven Rest Home. The facility manager is on site five days a week and is available by phone 24/7 if not on site. The facility manager is supported by two registered nurses (one clinical manager and one staff RN). The clinical nurse manager provides clinical oversight of the service. He has been in this role since July 2018. Prior to this role he was the facility manager at this facility.  The facility manager and clinical nurse manager have maintained at least eight hours annually of professional development relating to managing a rest home. |
| Standard 1.2.2: Service Management  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. | FA | During the temporary absence of the facility manager, the clinical manager is the acting manager with support from the care staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management programme is in place. Interviews with the facility manager, clinical manager and staff reflected their understanding of the quality and risk management systems that have been put into place. Policies and procedures are provided by an external consultant. A system of document control is in place with evidence of regular reviews. Staff are made aware of any policy changes through staff meetings.  The monthly collating and analysis of quality and risk data includes monitoring accidents and incidents, any complaints received, resident satisfaction and infection rates. Internal audits regularly monitor compliance. A corrective action form is completed where areas are identified for improvement. Staff are kept informed regarding results and actions via staff meetings. The quality programme is linked to the annual training plan with extra and impromptu training offered as issues are identified. Annual resident satisfaction surveys are completed. The last resident satisfaction survey results (March 2018) indicated that no corrective actions were required.  A health and safety programme is in place, which includes managing identified hazards. The activities coordinator/caregiver oversees the programme. Health and safety training begins during the new employee’s orientation. The topic of health and safety is discussed each month in the staff meetings. The hazard register is regularly reviewed and updated as new hazards are identified.  Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective actions. Fifteen incident forms reviewed for 2018 evidenced that appropriate clinical care is provided following an adverse event. Investigations were completed, and family notified as appropriate. All incident forms are signed off by the clinical manager.  The caregivers interviewed, could discuss the incident reporting process. The clinical manager collects monthly incidents, investigates and implements corrective actions as required. Records of events are collated per individual resident and for the facility as a whole.  Discussions with the facility manager confirmed that she is aware of situations in which the service would need to report and notify statutory authorities. This has not been required since the last audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity. Copies of current practising certificates for health professionals are held. Five staff files (one clinical nurse manager, one staff RN, two staff caregivers, one caregiver/activities coordinator) reviewed, evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service.  There is an education and training plan in place that meets contractual requirements. The clinical nurse manager has completed his interRAI training. There is a minimum of one staff available 24/7 who holds a current certificate in first aid and CPR. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.  The facility manager is on site five days a week and is on-call when not on site. She contacts an RN with any clinical issues.  The clinical manager works three days a week (20 hours) and a second RN has recently been employed and is scheduled to work three days per week (12 hours). This allows for an RN to be on site six days a week.  The roster includes two caregivers on the AM shift (one long and one short). One caregiver is rostered for the PM shift and one for the night shift. Caregivers are also responsible for cleaning and laundry. Interviews with caregivers and residents identified that staffing is adequate to meet the needs of residents.  Activities staff are scheduled Monday – Friday from 9:30 am – 12.00 pm. A cook is rostered from 7:00 am – 1.00 pm and a kitchen assistant assists with the evening meal. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | There are resident files appropriate to the service type. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. All entries in the progress notes are legible, dated and signed. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to safely guide service provision and entry to services including an admission policy. The service has information they offer residents on admission. The admission agreements reviewed meet the requirements of the ARCC. Exclusions from the service are included in the admission agreement. Five admission agreements sighted were signed and dated. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Policy describes guidelines for death, discharge, transfer, documentation and follow-up. A record of transfer documentation is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities and communication with family is made. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There was one resident self-administering on the day of audit. All legal requirements had been met. There are no standing orders in use. There are no vaccines stored on site.  The facility uses a paper-based and robotic pack system. They are currently in the process of introducing an electronic system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Medication competent caregivers administer medications. Staff have up-to-date medication competencies completed and there has been medication education in the last year. The medication fridge temperature is checked daily. Eye drops are dated once opened.  Staff sign for the administration of medications on medication signing sheets. Ten medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. ‘As required’ medications had indications for use charted. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service has two cooks, one who works Tuesday to Saturday and one who works Sunday to Monday. Both have current food safety certificates. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen and all meals are cooked on site. Meals are served directly from the kitchen to the dining room. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. The cooks prepare the evening meal and leave it for the caregivers to heat and serve. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents’ dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a whiteboard. The four-weekly menu cycle is approved by a dietitian. All residents and family members interviewed were satisfied with the meals.  The food control plan was approved on 26 June 2018. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The service records the reason for declining service entry to potential residents should this occur and communicates this to the potential residents/family. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents’ files reviewed. Overall the goals were identified through the assessment process and linked to care plan interventions. Other assessment tools in use included (but are not limited to) falls risk, pressure injury risk, pain and continence. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Interventions documented support needs and provide detail to guide care. Short-term care plans are in use for changes in health status. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow, and that the clinical manager always notified them of changes. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident’s condition changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative’s health status. All care plans sampled had interventions documented to meet the needs of the resident. Care plans have been updated as residents’ needs change.  Residents’ falls are reported on incident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their heads. Family are notified.  Care staff interviewed stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies.  Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurs as planned. There were two minor wounds being treated. There were no pressure injuries.  Monitoring forms are in use as applicable such as weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviours. |
| Standard 1.3.7: Planned Activities  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. | FA | There is one activities coordinator. He is also a caregiver but is allocated 20 hours a week for activities. He has attended activities study days but has not completed the diversional therapy course. On the day of audit, residents were observed doing exercises, and playing games. In the afternoon they enjoyed ‘happy hour’.  There is a weekly programme in large print on noticeboards. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents’ needs. These include exercises, games, quizzes, music, entertainment, outings and walks outside.  Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat. There is a volunteer who comes in twice weekly who assists with this.  There is a monthly Anglican Church service. Catholics are given communion by the local parish. There are van outings at least weekly. The week prior to the audit they had a picnic at Mission Bay. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Fathers’ Day, Anzac Day and the Melbourne Cup are celebrated.  The facility has one cat and a pet therapy team visits fortnightly. Families also bring in their pets.  There is community input from kindergartens, scout groups and cultural groups. The facility is just across the road from a library and mall, so residents often visit these. Three residents did this on the day of audit and enjoyed a cup of coffee while out.  Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the activity plan is based on this assessment. Activity plans are evaluated at least six-monthly, at the same time as the review of the long-term care plan. Resident meetings are held monthly. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The four long-term care plans reviewed (apart from one new admission) had been evaluated by the registered nurses six monthly or when changes to care occurs. Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activity plans are in place for each of the residents and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP if available and resident/family if they wish to attend. There are three-monthly reviews by the GP for all residents. The family members interviewed confirmed that they are informed of any changes to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Referral to other health and disability services is evident in the resident files reviewed. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There was evidence of where residents had been referred to the wound care nurse specialist and mental health services for older people. Discussion with the registered nurse identified that the service has access to a wide range of support either through the GP, specialists and allied health services as required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer’s labels and stored in locked areas. Safety datasheets and product sheets are available. A sharps container is available and meets the hazardous substances regulations for containers. The hazard register identifies hazardous substances and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness which expires 21 February 2019. There is no maintenance person on site but a maintenance person from another site is contacted when required. Contractors are used when required.  Electrical equipment has undergone annual safety testing. Medical scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. Hallways, lounges and resident rooms are carpeted. The dining room has vinyl that has recently been replaced. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring as well. One ensuite, communal showers and toilets have nonslip vinyl flooring. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well-maintained. All outdoor areas have seating and shade. There is safe access to all communal areas.  Caregivers interviewed stated they have adequate equipment to safely deliver cares. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All resident rooms have hand basins. Only one room has an ensuite. There are sufficient communal toilets and showers. Fixtures, fittings and flooring are appropriate for this setting. Toilet/shower facilities are easy to clean. There is ample space in toilet and shower areas to accommodate shower chairs if appropriate. There are privacy signs on all shower/toilet doors. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Although some rooms are certified to be double, there is currently only one room being shared by a couple. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge which is used for activities. The second lounge is slightly smaller and has shelves of books and a trolley with board games. This is suitable for residents who prefer quieter activities or visitors. The smaller lounge opens out onto an attractive deck. There is a spacious dining room. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is done on site. The laundry is run by the caregivers. The laundry is divided into a ‘dirty’ and ‘clean’ area. There is a laundry and cleaning manual. Cleaning and laundry services are monitored through the internal auditing system. The cleaner’s equipment was attended at all times or locked away in the cleaner’s cupboard. All chemicals on the cleaner’s trolley were labelled. There is one sluice room for the disposal of soiled water or waste and the sluicing of soiled linen if required. The sluice room and the laundry are kept locked when not in use. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency management policies and procedures implemented, guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked annually by an approved provider. The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation plan. A letter sighted from the New Zealand Fire Service (2004) confirms the approved evacuation scheme. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service.  Emergency supplies include sufficient water stored to ensure for three litres per day for three days per resident and enough food for three days. There is a civil defence kit and pandemic/outbreak supplies in the facility that are checked four-monthly. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking.  Emergency education and training for staff includes six-monthly trial fire evacuations. At least one staff member is on duty at all times with a current first aid certificate. Appropriate security systems are in place. Staff and residents interviewed confirmed they feel safe. Call bells are located in all resident areas including bedrooms and bathrooms. Resident interviews confirmed call bells were answered in an acceptable timeframe. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas have ample natural light and ventilation. All heating is electrical. Staff and residents interviewed stated that this is effective. There is a small courtyard where residents may smoke. All other areas are smoke free. |
| Standard 3.1: Infection control management  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. | FA | The clinical manager is the infection control coordinator (ICC). Responsibility for infection control is described in the job description. The ICC oversees infection control for the facility and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by an external consulting company.  Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine. There have been no outbreaks. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has completed a six-month infection control course through Waiareki Polytechnic. He has also completed an on-line Ministry of Health (MOH) course. There is access to infection control expertise within the DHB, the wound nurse specialist, public health, and the laboratory. The GP monitors the use of antibiotics. The ICC also liaises and meets regularly with the facility manager. |
| Standard 3.3: Policies and procedures  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. | FA | The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by an external consultant. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The ICC is responsible for coordinating/providing education and training to staff. Training on infection control is included in the orientation programme. Staff have completed an infection control study day this year. The ICC has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The ICC collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends, is discussed at staff and management meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. The facility benchmarks with other facilities of a similar size.  Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Glenhaven Rest home has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were no residents using restraints or enablers. The restraint coordinator (clinical manager) confirmed that the service promotes a restraint-free environment. Restraint education is included in the two-yearly training programme and last occurred in May 2017. |

# Specific results for criterion where corrective actions are required

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

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

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

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| No data to display |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.