

Udian Holdings Limited - Glencoe Resthome

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Udian Holdings Limited
Premises audited:	Glencoe Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 November 2018 End date: 29 November 2018
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	12

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	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

Glencoe Rest Home is one of three aged related residential care services owned by one of the directors and provides care for up to 15 residents requiring rest home level care. At the time of this certification audit 12 beds were occupied.

This audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies, procedures, residents' and staff files, observations and interviews with residents, families, a general practitioner, the two directors and staff.

There is one area identified for improvement related to reviewing policies to ensure they are relevant to this service.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication was evident between staff, residents and families, is promoted and was confirmed to be effective. The service has access to an interpreter service if required. Staff provide residents and families with appropriate information they need to make informed choices and to give informed consent.

Residents who identify as Maori have their needs met in a manner that respects their individual culture, values and beliefs. Staff were well informed of their responsibilities in relation to any evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialists at the district health board to support best practice and to meet the needs of the residents.

Complaint forms are available to residents and family members. Any complaints or concerns are investigated and responded to in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The organisation's philosophy, mission and goals/objectives are documented in the business plan. The facility manager is one of the company directors and works with the owner and the registered nurses, to ensure the services offered meet residents' needs, legislation and good practice standards.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit programme, complaints management, incident/accident reporting, corrective action planning, hazard management, and infection control data collection. Quality and risk management activities and results are shared with management and staff. Corrective action planning is well documented. An external consultant develops policies.

New staff have an orientation. Staff participate in regular, relevant ongoing education. Applicable staff and contractors maintain current annual practising certificates. Residents and family members confirmed during interview that all their needs and wants are met. The service has a documented rationale for staffing which is implemented.

Residents' information is accurately recorded, securely stored and is not accessible to unauthorised people.

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.
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Access to the facility is appropriate and managed effectively with relevant information provided to the resident/family on admission.

The registered nurse and general practitioner assess residents' needs on admission in a timely manner. Care plans are individualised based on a range of information and accommodate any new problems that might arise. Records reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health providers/services as required.

The planned activities programme provides the residents with a variety of individual and/or group activities. Interests of the residents are considered. Links with the community are encouraged at every opportunity.

Medicines are safely managed. Staff complete medicine management competencies on an annual basis.

The food service meets the nutritional needs of the individual residents and special needs are catered for. Food is safely managed. Residents verified satisfaction with 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.
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Policies and procedures were available to guide staff in the safe disposal of waste and hazardous substances. Appropriate supplies of personal protective equipment were readily accessible for staff use. Staff have been trained on chemical safety.

The building has a current building warrant of fitness. Clinical equipment has current calibration. Electrical safety checks of electrical appliances are occurring. The security arrangements and practices were appropriate.

There are 13 single occupancy bedrooms and one share twin bedroom. All have hand washing facilities present. There is one full bathroom with a toilet and shower and four separate toilets for residents' use. Call bells were present in the bedrooms and bathrooms. Personal space was sufficient for residents, including those who require staff assistance or the use of mobility devices. There is a separate lounge and dining area. There is indoor/outdoor flow with deck and garden areas for the residents and their families to use. The facility has adequate heating and ventilation. There is no smoking on site.

Cleaning and laundry services are provided. These services were monitored through the internal audit programme. Residents and family members interviewed confirmed the facility was kept clean and warm.

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has a commitment to a `non-restraint policy and philosophy`. The restraint minimisation and safe practice policy details expected practice. There was no restraint or enablers in use at the time of the audit. The front gate to the property is kept closed and residents and family are given the code to open and sign applicable consents at admission in relation to this. Staff interviewed had a good understanding that the use of enablers was a voluntary process. Safety was always promoted for residents. Staff have access to education on managing challenging behaviour and complete restraint competencies.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme is led by the registered nurse who aims to prevent and manage infections. The programme is reviewed annually. Advice is accessible when needed. Staff demonstrated a good understanding of the principles and practice around infection prevention and control. Policies and procedures are available to guide staff and the staff are supported by an ongoing infection control education programme.

Aged specific infection surveillance is undertaken which is practicable for the size and nature of this small aged care service. Any results of surveillance are reported to the manager and reported back to staff. Follow-up action is taken as and when needed.

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	44	0	1	0	0	0
Criteria	0	92	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Glencoe Rest Home has developed and implemented policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity, respect and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training. This was verified when reviewing the 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>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents' records reviewed had consent forms signed by the resident, and/or family and/or enduring power of attorney (EPOA). Advance directives are encouraged and discussed at the time of admission and signed by the resident if competent. None of the sampled files contained advanced care plans. Family/whānau interviewed stated that their relatives were able to make informed choices around the care they received, and families/whānau were actively encouraged to</p>

		<p>be involved in their relative's care and decision making.</p> <p>Residents interviewed stated that they were able to make their own choices and felt supported in their decision making. Staff interviewed acknowledged the resident's right to receive, refuse and withdraw consent for care/services. Staff interviewed demonstrated good knowledge of informed consent as evidenced in the progress records, care planning and observations at the time of audit.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>All residents receiving care within the facility have appropriate access to independent advice and support, including access to cultural and spiritual advocates whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were encouraged to become actively involved as an advocate for their relative and felt comfortable with speaking with staff.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and family/whanau are encouraged to visit. Residents are fully supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident's progress records and care planning, such as visiting the local shopping mall or community groups visiting the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Glencoe Rest Home implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family and staff reported their understanding of the complaints process and noted they had no complaints. Complaints forms are present near the main entrance and include an area for the recording of complaints, feedback and compliments.</p> <p>A complaints register is maintained. Complaints are infrequent and are investigated and responded to in a timely manner and records are maintained. There have been no complaints received from the Ministry of Health (MOH), Counties Manukau District Health Board (CMDHB) or the Health and Disability Commissioner (HDC) since the last audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The policy identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and is also evidenced in the admission agreement. The information packs were reviewed for those enquiring about the service and the pack for residents/whanau when the resident is admitted to the facility. The Code is displayed in all service areas together with information on advocacy services, how to make a complaint and feedback forms.</p> <p>The family/whanau and residents that were interviewed reported that the Code was explained to them on admission. Family/whanau and residents expressed satisfaction with the care at the facility provided by the staff.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>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 were observed to maintain privacy throughout the audit. Most residents have a private room. There is one shared room with two residents. A curtain is provided for maintaining privacy.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and/or the activities programme, however, participation is voluntary. Care plans sighted included documentation related to the resident's abilities and strategies to maintain independence.</p> <p>Records reviewed confirmed that each resident's cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their individual care plan.</p> <p>Staff understood the service's policy on abuse and neglect including what do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and is provided annually.</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>Staff support residents in the service who identify as Maori to integrate their cultural values and beliefs. There are four residents who identify as Maori. No Maori staff are currently employed. Two registered nurses and caregivers interviewed reported that there are no barriers to Maori accessing the service. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori residents and importance of whanau and their Maori culture. A Maori Health Plan for the organisation was available and was being reviewed at the time of the audit.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The residents' records reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The family/whanau interviewed reported that the staff are meeting the needs of their relatives and that their relative was treated in a manner that supported their cultural beliefs and values. This was also evidenced at the time of audit with observed interactions.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family/whanau and residents reported that they are pleased with the care provided. The families/whanau expressed that staff knew their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries. Responsibilities were clearly outlined in the job descriptions reviewed.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Evidenced-based practice was observed and evidenced in interviews with the two registered nurses, caregivers and through care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by the general practitioners, links with other health professionals, palliative care nurses, geriatricians and different DHB nurse specialists and allied health staff. Care guidelines are utilised as appropriate. The residents' records are well maintained regularly reviewed and audited. It was noted that there had been an increase in the influenza vaccinations for staff and residents and the service had achieved 100% coverage.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The family/whanau interviewed confirmed that they are kept informed of their relative's well-being including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of open disclosure was seen in the residents' progress records, accident/incident forms and at shift handover.</p> <p>The staff communication book was reviewed as a means of communication between staff and the shift handover was observed.</p> <p>All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. Residents are from many different cultures and staff are often requested to provide interpretation or to translate a document. Where hospital/consultant</p>

		<p>appointments were planned, the option of formal interpreters to support the residents and family/whanau were encouraged. The Counties Manukau District Health Board (CMDHB) provides an interpreter service if required and information is accessible for staff should this be required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Glencoe Rest Home is one of three aged related care facilities providing rest home level of care owned by one of the facility directors. Each rest home is operated as a separate entity. Glencoe Rest Home has a documented mission statement, philosophy and values that are focused around the provision of individualised, quality care in a warm, loving environment. The facility manager, who is also one of the two company directors, lives on site and is confirmed to be readily available to residents and family.</p> <p>The facility manager monitors the progress in achieving goals via day to day activities, resident / family feedback and monitoring of the results of quality and risk activities. The day to day operations and ensuring the wellbeing of residents is also the responsibility of the facility manager. The facility manager has worked at Glencoe Rest Home since the rest home was purchased, and prior to this, has worked in a range of senior information technology / communication roles both in New Zealand and overseas. The facility manager participates in relevant ongoing education as required to meet the provider's contract with CMDHB. The owner / director was interviewed and confirmed having conversations with the facility manager on at least a daily basis and sooner where required and verified being fully informed of business and quality and risk issues in a timely manner.</p> <p>Since the last audit there has been some refurbishment of the facility. Some of the bedrooms have been repainted, and the shower room renovated. This aligns with facility goals.</p> <p>The registered nurse, who works 32 hours each week on site, has worked as a RN overseas and obtained New Zealand registration in early 2018. The registered nurse is mentored and supported by the facility/clinical manager from one of the other three rest homes in this group, who also works on site at Glencoe Rest Home four hours a week. This facility/clinical manager advises she is also available to provide support/advice via phone at any time. Both registered nurses have current interRAI competency.</p> <p>The service has a contract with CMDHB for the provision of aged related residential rest home level care. A contract is also held for long term support chronic health conditions residential – rest home level of care. There is another contract with CMDHB for the provision of short term care for people with a main carer - residential facility rest home level, and for short term care for people with chronic health conditions – residential facility at rest home level of care. All residents are reported to have been assessed as requiring rest home level care. There were 11 residents receiving care under the ARRC rest home contact; this includes one resident who is receiving services from the DHB mental health team. There was one resident under the age of 65 years, who was receiving services under</p>

		the long term support chronic health conditions contract at rest home level of care. There were no short term residents and no boarders.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The registered nurse, who works 32 hours each week on site, is responsible for services in the facility manager's absence. The RN is supported by the owner / director, and the facility/clinical manager at another of the three rest homes in this group as required.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>Glencoe Rest Home has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, benchmarking, health and safety reporting, hazard management, infection control data collection and management, and complaints / compliments management. Restraints are not in use. Regular internal audits are conducted, which cover relevant aspects of service including aspects of care, documentation and medicine management.</p> <p>A resident satisfaction survey was conducted in May 2018. Staff, resident and family members interviewed expressed a high level of satisfaction about the services provided at Glencoe Rest Home.</p> <p>If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions were developed and implemented. Quality information is shared with all staff via shift handover as well as via the monthly staff meetings. The minutes of staff meetings are made available to staff. Staff interviewed verified they were kept well informed of relevant quality and risk information. Opportunities for improvement are discussed, along with the organisation's expectations / policies.</p> <p>Meetings are held monthly with residents to obtain resident feedback on services, food, and activities as well as to obtain information for future planning. The minutes of the last three meetings were sighted.</p> <p>Policies and procedures were readily available for staff. One paper copy of documents is available for staff. The facility manager is responsible for document control processes including archiving. Some of the most recent policies that have been developed by an external consultant have yet to be localised to reflect the services and environment at Glencoe Rest Home.</p> <p>Actual and potential hazards and risks are identified in the risk and hazard registers. These contain</p>

		<p>potential and actual hazards and risks. Mitigation strategies have been documented. Staff confirmed that they understood and implemented documented hazard identification processes. Maintenance issues are reported in real time and the records sighted verified reported events have been promptly addressed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Policy and procedures detail the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation and as a component of the ongoing education programme.</p> <p>Applicable events are being reported in a timely manner. A review of reported events including falls, a skin tear, and a medicine error demonstrated that incident reports are completed, investigated and responded to in a timely manner. Staff communicated incidents and events to oncoming staff via the shift handover. Events have been discussed with staff at the staff meetings as verified by interview and detailed in meeting minutes sighted. Incidents (eg, falls and wounds) are included and summarised in the incident register present in each resident's file. The number and type of incidents are analysed and communicated to staff each month.</p> <p>The facility manager and the owner / director advised there have been no events that have required essential notification. The facility manager and the owner were able to detail the events that require reporting.</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>	FA	<p>Copies of the annual practising certificates (APCs) were sighted for four general practitioners (GPs), the pharmacists, the podiatrist, the dietitian, and the two registered nurses.</p> <p>Recruitment processes includes completing an application form, conducting interviews and reference checks. Recruitment and training records of staff are maintained and include the job description, police vetting, reference checks, interview, a confidentiality agreement, orientation / induction record, and annual practising certificate (where applicable).</p> <p>Performance appraisals have been undertaken with new staff who have been employed at three months, and then are conducted annually thereafter.</p> <p>New employees are required to complete a health and safety induction and an orientation programme relevant to their role. A checklist is utilised to ensure all relevant topics are included. New employees are buddied with senior staff for at least two shifts until the new employee can safely work on their own.</p>

		<p>A staff education programme is in place with in-service education identified and provided monthly. This includes internal and external education sessions / speakers. The topics meet the requirements of the provider's contract with CMDHB and these standards. Attendance is mandatory unless exceptional circumstances present. Records of attendance are maintained and demonstrated a high level of attendance by staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A policy details staffing levels and skill mix requirements and this aligns with the requirements of the provider's contract with CMDHB. There were no staff vacancies.</p> <p>The current roster, along with the previous three weeks roster, was reviewed. There is a RN on duty 32 hours a week (weekdays), and another senior RN (refer to 1.2.2.1) works four hours a week on the weekend. Both RNs have current interRAI competency.</p> <p>The manager is on site most days and provides meal services and assists with residents' care. The manager and the RN (who works 32 hours a week) are on call when not on site. This was verified by interview with the RN, manager and caregivers. The staff responsible for food services have completed food safety training.</p> <p>One caregiver works 7am to 3pm, 3pm to 12 pm, and 12 pm to 9 am. A caregiver also facilitates the activities programme with activities planned three days a week. Cleaning and laundry duties are shared by caregivers over the 24 hour period. Laundry is washed on site then dried off site at a commercial laundry during the day if the laundry is unable to be dried on the external clothes line.</p> <p>A staff member with a current first aid certificate is on duty at all times. The facility manager advised that additional staff hours are allocated to meet the care needs of the residents if required.</p> <p>Residents and the family member interviewed confirmed their personal and other care needs are being well met.</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) are used as the unique identifier on all resident's information sighted. Clinical records were current and integrated with general practitioner (GP) and auxiliary staff records. The records were being kept secure in all nurses' stations and were only accessible to authorised people. On the day of admission, all relevant information is entered into the resident's record by the registered nurse following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and contact phone numbers were all completed in each resident's record</p>

		<p>reviewed.</p> <p>No personal or private resident information was observed to be on public display during the days of the audit.</p> <p>Full residents' records remain traceable and held within the required time frames which also encompass the requirements of the (Retention of Health Information) Regulations 1996 Act.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The organisation has a developed admission agreement which is based on the Aged Care Association agreement. The resident's records reviewed have signed admission agreements by the resident/family/representative or enduring power of attorney (EPOA). Information packs for residents and families admitted to this rest home service were available and reviewed. All residents must be assessed prior to entry to this service by the needs assessment service coordinator (NASC) from the district health board (DHB).</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner. An escort is provided as appropriate. The service utilises the 'yellow envelope' system when transferring a resident to the DHB acute care services. There is open communication between all services, the resident and family/whanau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident ensuring continuity of service provision. All referrals were documented in the progress records and a copy of the referral retained in the individual resident's records sighted.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of the audit. The staff observed demonstrated sound knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The registered nurse checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request and a six monthly audit is completed.</p>

		<p>The records of temperatures for the medicine fridge were maintained. There is no medication room but a locked trolley and cupboard was sighted. Vaccines are not stored on site. Hard copy records were observed that included the GP name and registration number and dates of all reviews undertaken by the GP. All requirements for pro re nata (PRN) medicines are met. The outcomes or effect of medication given is recorded. Standing orders are not used.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner if required.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The facility manager oversees the food service and is supported by the care staff on duty each day. The four week menu plans have been audited and approved by a dietitian on the 15 November 2018. The main meal is provided at lunchtime. All baking and meals are cooked on-site in the main kitchen. The dining room is in close proximity to the kitchen. The registered nurse completes a dietary profile for each resident when they are admitted to the service and a copy is retained in the kitchen. Any food allergies or preferences are noted in a folder sighted. Profiles are reviewed six monthly. There is evidence that additional snacks are available over the 24 hours if required.</p> <p>All aspects of food procurement, production, preparation, delivery and storage comply with current legislation. Temperatures are monitored and recorded daily of the freezer and fridges. Dry goods are stored appropriately in the pantry and rotation is noted with goods dated. Chemicals are stored safely. Cleaning schedules are maintained. Staff have completed food safety education and chemical safety training. The service is registered for the required food safety plan. Special equipment to meet resident's nutritional needs is available. There is a first aid box in the kitchen and personal protective resources are readily available. The residents interviewed were satisfied with the meals provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The two registered nurses interviewed reported that the service does not refuse a resident if they have had a suitable NASC assessment to evidence the level of care and there is a bed available. In an event that the service cannot meet the needs of the resident, the resident, family/whānau and the NASC service will be contacted so that alternative residential care accommodation can be found. An example would be if a resident required hospital level care or dementia care. The resident agreement has a clause which states when an agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the individual resident.</p> <p>Staff reported that declining access for residents rarely occurs and full assistance would be</p>

		provided to the family/whanau and resident during this process.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and other tools as deemed necessary, as a means to identify any deficits or triggers to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have had an interRAI assessment completed. The two registered nurses are interRAI trained. Residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. Allergies and sensitivities are recorded on the care plan, the medical records and the medication record. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress records and activities records. The GP's notations are clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available appropriate 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</p>	FA	<p>The monthly activities programme is provided by one activities coordinator who works 16 to 20 hours per week. The activities programme covers Monday to Friday. The coordinator completes a social assessment and history. An individual activities plan is developed for each individual resident and is reviewed when the care plans are evaluated six monthly or earlier if required.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community</p>

<p>the service.</p>		<p>activities. Individual, group activities and regular events are offered. Residents and families/whanau are involved in satisfaction surveys, including related to the activities programme. The feedback was very positive. The activity timetable is displayed in all the dining rooms. Residents receive a copy for their room. Photo boards and albums display photos of special events held. Residents' interviewed confirmed they find the programme enjoyable. Activities evaluations are completed six monthly and attendance records are maintained by the coordinator who has been a caregiver for fifteen years and in this activities role for four years. A van is available for external outings into the community.</p>
<p>Standard 1.3.8: Evaluation 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 records. If any change is noted it is reported by staff to the registered nurse.</p> <p>Formal evaluations of the care plans occur six monthly in conjunction with the six monthly interRAI reassessment or as a resident's needs change. Where progress is different from expected the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for eye infections, wound care and skin tear management. When necessary for unresolved problems, the long term care plans are updated accordingly. Residents and family/whanau interviewed provided examples of involvement in evaluation of progress and resulting changes.</p>
<p>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.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a resident doctor residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested the general practitioner or registered nurse sends a referral to seek specialist input. Copies of referrals were sighted in residents' records. The resident/family/whanau are kept informed of the referral process as verified in the documentation and interviews. Any acute/urgent referral is 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 Consumers, visitors, and service providers are protected from harm as a result of exposure to waste,</p>	<p>FA</p>	<p>Policies detail how waste is to be segregated and disposed. The policy content aligns with current accepted practice.</p> <p>Chemicals sighted were stored in designated and secure areas. Material safety data sheets detailing actions to be taken in the event of exposure were sighted for chemicals in use. Staff have</p>

infectious or hazardous substances, generated during service delivery.		<p>been provided with training on chemical safety and handling, most recently in August 2018.</p> <p>Appropriate personal protective equipment (PPE) was available on site including disposable gloves, aprons, masks, and face protection.</p> <p>Staff advised they would report inadvertent exposures to hazardous substances and blood and body fluids to the manager. Staff confirmed receiving education on handling chemicals and waste as part of the orientation and ongoing education programme.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness (expiry date 16 March 2019) is displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, and observation of the environment. Hot water temperatures are monitored monthly on a rotating basis in resident care areas and are within the required range. The environment was hazard free, residents were safe and independence is promoted. Grab rails are present in the bathrooms and corridors.</p> <p>The facility vehicle has a current registration and warrant of fitness.</p> <p>External areas are safely maintained and were appropriate to the resident groups and setting. Staff confirmed they know the processes they should follow if any repairs or maintenance is required, that any requests are appropriately actioned and that they are happy with the environment. Renovation and refurbishment is ongoing. The annual plan details the aspects to be completed during the year.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible toilet facilities throughout the facility. There is one shower. Staff advised this is sufficient as residents shower throughout the day. Privacy locks and signs are present. Hand basins are present in each resident's bedroom. Appropriately secured handrails are provided in the toilet/shower areas. There are separate toilet facilities for staff and visitors to use.</p>
Standard 1.4.4: Personal Space/Bed	FA	Adequate personal space is provided to allow residents and staff to move around within their

<p>Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>		<p>bedrooms safely. Thirteen bedrooms provide single accommodation, and one bedroom has twin occupancy. Rooms are personalised with furnishings, photos and other personal items displayed. Residents were sighted mobilising inside and outside the facility independently and with staff support, including while using a mobility aid. There are appropriate privacy curtains present in the twin occupancy room.</p> <p>The staff interviewed advised there is sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The majority of residents have single occupancy rooms. There is an open planned lounge and dining room, and several outside areas on the deck and in the garden that has appropriate furniture and shade. The residents and family members interviewed confirmed that there is sufficient space available for residents and support persons to use in addition to the residents' bedrooms.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Policies and activity lists detail how the cleaning services are to be provided. All laundry including resident's personal clothing is washed daily by the caregivers. There is one washing machine on site. Laundry is dried on external lines or taken to a local laundromat.</p> <p>The residents and family members interviewed confirmed the rest home and hospital is kept clean and tidy and residents' laundry is normally washed and returned in a timely manner. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated compliance with the service requirements. The resident satisfaction survey includes questions related to environmental cleanliness and laundry services.</p> <p>Chemicals are stored in designated rooms which are locked. Two caregivers interviewed confirmed being provided with training on the safe handling of chemicals and had written instructions readily available on the use of products and required cleaning processes / activities. Each resident's bedroom is 'spring cleaned' on a rotating basis.</p> <p>Instructions for managing emergency exposures to chemicals is readily available to staff.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed in a wall mounted flip chart and known to staff.</p>

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>A fire evacuation plan was approved by the New Zealand Fire Service with a letter to the provider verifying this sighted; dated 30 November 2015. A trial evacuation takes place six-monthly with a copy of the report sent to the New Zealand Fire Service. The most recent fire drill was conducted on 20 November 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including dry food for seven days, water, woollen or fleece blankets, wet wipes, continence products, other commonly used consumables, and a gas BBQ were sighted and meet the requirements for up to 15 residents. There are multiple bottles of drinking water stored in the attic. All emergency equipment is regularly checked and rotated. Staff have access to a mobile phone.</p> <p>Call bells alert staff to residents requiring assistance. They alert via an audible sound and notification of the room number/location through to a centralised panel. A call bell tested at random was fully functioning. Call bells are tested monthly as part of the monthly internal audits. Residents and families reported staff respond promptly to call bells, and this was observed during audit.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time. Staff are required to visually check residents at least hourly overnight. Security checks are documented on caregiver checklists as being completed. External and internal security cameras are in use monitoring public areas. Signage alerts residents and visitors that these are in use. Written consent for the use of these cameras is now included in the admission agreement, with residents admitted prior to the admission agreement being updated signing a separate written consent. The external gate and one external door has keypad entrance (refer to 2.1.1).</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 and opening external windows. Heating is provided by wall mounted electric heaters in bedrooms and heat pumps are present at the end of each corridor and in the lounge. Areas were at an appropriate temperature and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. One of the external doors was observed to be kept open throughout the day.</p> <p>There is a designated external area for residents who smoke. There were no current residents that smoke.</p>
<p>Standard 3.1: Infection control management</p>	<p>FA</p>	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p>

<p>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>The infection control coordinator is a registered nurse and had only been in this role for a few months at the time of the audit. The infection control coordinator (ICC) holds accountability and responsibility for following the programme in the infection control manual reviewed. The ICC interviewed monitors for infections, by using standardised definitions to identify infections, surveillance activity, changes in behaviours, monitoring or organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at meetings. If there is an infectious outbreak this is reported immediately to staff, management and where required to the DHB and public health services.</p> <p>The registered nurse interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans are implemented, and this is documented in the progress records. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, the staff communication book, one on one communication, at shift handover, in short term care plans and in resident's documented progress records.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance to the facility saying not to visit if the visitor has come in contact with people or services that have outbreaks identified. There have been no outbreaks since the previous audit. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The registered nurse has been newly appointed to this role but is experienced, is fully trained and has completed appropriate education at the DHB. The registered nurse is well supported by the other registered nurse interviewed. The GP, registered nurses and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing techniques were observed.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures</p>	<p>FA</p>	<p>An infection prevention and control policy (reviewed October 2018) sets out the expectations the organisation and facility uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, wound management, blood and</p>

<p>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>		<p>body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The registered nurses and caregivers interviewed could demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing audits occur on a regular basis. Infection control in-service education is held as per the education plan reviewed and is facilitated by the registered nurses. Resident education is provided as and when appropriate.</p>
<p>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.</p>	<p>FA</p>	<p>All staff are required to take responsibility for surveillance as shown in policy. Monitoring is discussed in meetings to reduce and minimise risk and to ensure residents' safety. The ICC reports to the manager and provides a monthly surveillance report. The service monitors respiratory infections, wounds, skin, ear nose and throat, urinary tract infections and gastroenteritis. The monthly analysis of infections includes comparison with the previous month, reason for the increase or decrease, trends and actions taken to reduce infections. This information is fed back and discussed in staff meetings and where appropriate with family/residents. Overall monthly statistics remain low for the size and services provided at the facility. Short and long term care plans were evidenced to document interventions to reduce and minimise the risk of infections and regular evaluations.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Glencoe Rest Home has a 'non-restraint' philosophy. A register of restraint and enabler use was available. There have been no restraints or enablers used since the last audit. Staff have access to guidelines for the management of emergency situations and episodes of challenging behaviour. There are clear definitions on restraint minimisation and safe practice and enabler management. The staff interviewed had a good understanding of enablers and that they were only used in a voluntary capacity to aid resident's independence. Staff are provided with training on restraint minimisation and the use of enablers and have current competency. Training is also provided on managing challenging behaviour.</p>

		<p>Environmental restraint was acknowledged for the front gate which is kept locked for safety purposes as the rest home is on the corner of two main roads. A bell system for entry is present at the front gate. The keypad code to obtain entrance is also written on the keypad outside the gate. A push button is used to open the gate from the inside. One of the external doors to the rest home also has keypad exit. The code is written on the adjacent keypad. The service has recently consulted an external company about changing this exit area and the associated emails were sighted. The door and gate are reported to be linked to the fire alarm and automatically open if the fire alarm is activated. During audit, at least one external door to the rest home was observed to be kept open to enable the resident's freedom of movement.</p> <p>Consent was obtained in relation to the locked gate from all residents/family/whanau on entry to the service. An instruction sheet was sighted and consent forms were signed appropriately in all sampled files. Two family members and five residents interviewed verified there were no restrictions on residents going outside or accessing the community. Staff assist residents mobilising outside as required. The family members advised they were given the code to the gate when their family member was admitted.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	Policies and procedures were readily available for staff in paper copy and have been developed by an external consultant. Some policies (including but not limited to) the health and safety policy, and good employer policy have not been localised to reflect the specific needs of Glencoe Rest Home.	An external consultant has developed policies and procedures. Not all policies have been reviewed and localised for this facility.	<p>Ensure new policies and procedures are reviewed to ensure content is relevant to this service and facility.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.