

# Masonic Care Limited - Glenwood Masonic Hospital

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## 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:

<b>Legal entity:</b>	Masonic Care Limited
<b>Premises audited:</b>	Glenwood Masonic Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 3 December 2018      End date: 4 December 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	43

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Glenwood Masonic Hospital provides residential care for up to 44 residents who require rest home and hospital level care. The facility is operated by Masonic Care Limited.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, the chief executive officer, a nurse practitioner and a general practitioner.

Continuous improvement ratings have been awarded relating to the presentation of pureed food and extending the hours for planned activities during the week and providing activities at the weekends.

Areas requiring improvement relate to residents' care plans not fully describing required support, ongoing medication training and monitoring of cleaning and laundry processes.

## 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's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Masonic Care Limited - Glenwood Masonic Hospital. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

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

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

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

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

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

The complaints register is up to date. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

## 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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Masonic Care Limited is the governing body and is responsible for the service provided. A strategic business plan includes a purpose, vision, values and goals. There is regular reporting by the facility manager to the chief executive officer who reports to the trust board.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a clinical nurse leader who is responsible for the clinical service.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Quality meetings include infection control, restraint and health and safety. Staff, resident, registered nurse (RN)/enrolled nurse (EN) meetings are all held on a regular basis.

There are policies and procedures on human resources management. Human resource processes are followed. An in-service education programme is provided for staff.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The facility manager and clinical nurse leader are rostered on call after hours.

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

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Glenwood Masonic Hospital works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a range of information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that files are reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

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

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

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

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents' bedrooms provide single accommodation. Residents' rooms are large and provide good personal space. Lounges, dining areas and alcoves are available. External areas for sitting and shading are provided. An appropriate call bell system and security and emergency systems are in place.

Protective equipment and clothing are provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site.

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The restraint policy reflects the requirements of the restraint minimisation and safe practice standard and identifies the use of enablers is voluntary and the least restrictive option to meet residents' needs. At the time of audit there were seven residents using restraint and four residents using an enabler.

## 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, led by an appropriately trained infection control coordinator, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

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

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

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	47	0	2	1	0	0
<b>Criteria</b>	2	96	0	2	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Glenwood Masonic Hospital (Glenwood) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Glenwood Masonic has its own residents' advocate, who attends residents' meetings. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff were aware of who the residents advocate was, and how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy, flow chart and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available throughout the facility.</p> <p>The complaints register shows five complaints for 2017 and 11 for 2018 have been received since the previous audit. The facility manager (FM) is responsible for the management of complaints. Documentation was reviewed for two complaints and evidenced Right 10 of the Code has been met. Staff interviewed demonstrated a good understanding of the complaint process and what actions are required.</p> <p>The FM reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>	FA	<p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed on posters around the facility. Brochures on the Code, information on advocacy services, how to make a complaint and feedback forms are available</p>

rights.		in the entry foyer. A residents' advocate attends residents' meetings.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information, discussion with families, the general practitioner (GP) and the nurse practitioner (NP). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training records.</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>	FA	<p>There were no residents in Glenwood at the time of audit who identified as Māori, however interviews verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers from the Wairarapa District Health Board (WDHB).</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</p>	FA	<p>Residents of Glenwood verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in all care plans reviewed, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>

respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents of Glenwood and their family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP and NP also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RN's) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dietician, psycho-geriatrician and mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support to undertake internal and external education. Management provides staff with access to up to date clinical procedures via an online clinical procedures website, access to online training sites, access to training through the WDHB and access to other external inservice training opportunities.</p> <p>All RNs have completed the fundamentals of palliative care training and syringe driver competency training. Healthcare assistants (HCAs) have or are encouraged to complete the fundamentals of palliative care training. HCAs are supported to gain higher qualifications through an external training provider, to increase nursing knowledge and improve the provision of quality support to residents of Glenwood. Staff have access to online training if they are unable to attend inservice training. Staff are remunerated for attendances at inservice training and undertaking on-line training.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the WDHB, in addition to accessing on line interpreting/translation services via tablets or phones.</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>Masonic Care Limited is governed by a board of seven trustees who meet 11 times a year. A strategic business plan 2016-2021 includes a purpose, vision, mission, goals and operational development. Board meeting minutes evidenced reporting to the board against four goals. The FM and chief executive officer (CEO) discuss activities relating to Glenwood Masonic Hospital via phone at least weekly. The FM provides a monthly report to head office which includes a wide range of subjects, including but not limited to, facility performance, care reporting, including falls, pressure injuries, complaints, staffing, investigations and any essential notifications. 'Quad' meetings are held two monthly that consist of representatives from the Masonic group's facilities. The meetings are chaired by the CEO and include a range of subjects including policy and procedure review and updating. Review of meeting minutes and interview of the FM confirmed this.</p> <p>The service philosophy and mission statement are in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service.</p> <p>The facility manager has extensive experience in the aged care sector, is an RN and was appointed to the position in June 2015. The FM is supported by a clinical nurse leader (CNL) who is a registered nurse and was appointed to their current position in October 2016. Prior to this appointment, the CNL was in an acting capacity. The CNL is responsible for oversight of clinical care. The FM and CNL are supported by head office staff. Interview of the FM and CNL and review of their personal files evidenced they have undertaken on-going education in relevant areas.</p> <p>The care planning policy includes the requirement for interRAI assessments. Five of the seven RNs are interRAI trained and have current competencies.</p> <p>Glenwood Masonic Hospital is certified to provide hospital and rest home level care. On the first day of audit there were 19 hospital level care residents including three residents under the 'Occupational Right Agreement' (ORA), (two hospital level and one ACC.) There were 24 rest home level care residents including four residents under the 'Occupational Right Agreement' (ORA). There were four residents under the age of 65 years, (one YPD, one hospital, one rest home and one ACC).</p> <p>The service has contracts with the DHB to provide Aged Related Residential Care, Health Recovery Programme, Long Term Support – Chronic Health Conditions' 'Residential Care for Palliative Care Patients' and 'Respite Services'. Contracts are also held with the Ministry of Health and ACC for three of</p>

		the four residents under the age of 65 years.
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the absence of the facility manager, the clinical nurse leader deputises for the facility manager. When the clinical nurse leader is absent, the facility manager is responsible for clinical oversight. The facility manager and clinical nurse leader confirmed their responsibility and authority for these roles. Support is also available from head office.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A risk management plan is used to guide the quality programme. Purpose, goals and objectives and scope are included in the plan.</p> <p>The resident satisfaction survey was completed in 2018 and results indicated that residents and families were satisfied with the services provided.</p> <p>Completed audits for 2017 and 2018, clinical indicators and quality improvement data was recorded on various registers and forms. Review of the quality improvement data provided evidence the data was being collected, collated, and analysed to identify trends and corrective actions are developed, implemented and evaluated. Quality data is benchmarked including graphs, by an external agency and within the group.</p> <p>Management, quality (including infection control, health and safety and restraint), staff and RN/EN meetings are held monthly and minutes were reviewed. The FM and quality coordinator stated quality data is discussed at the various meetings. There was documented evidence of reporting on various clinical indicators and quality and risk issues in these meetings. Staff reported that copies of meeting minutes and graphs are available for them to review in the handover room. This was confirmed by observations during the audit. Satisfaction surveys for 2018 were reviewed and demonstrated residents including those under the age of 65 years were complimentary of the care provided.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice, and reference legislative requirements. Policies / procedures are reviewed and were current. Staff confirmed they are advised of updated policies and that the policies and procedures provided appropriate guidance for the service delivery.</p> <p>A health and safety manual is available. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management,</p>

		legislative compliance, contractual risks and clinical risk.
<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>An open disclosure policy is in place. Staff are documenting adverse, unplanned or untoward events on an accident/incident form. The CNL is responsible for receiving and reviewing the accident/incident forms. The quality coordinator/EN is responsible for inputting the data. Incidents/accidents are investigated and corrective actions put in place.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change to the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>The FM stated they are aware of essential notification reporting to external agencies. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM reported there have not been any essential notifications since the previous audit.</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>	PA Low	<p>There are policies and procedures on human resources management. The skills and knowledge required for each position was documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed along with employment agreements, confidentiality statements, professional boundaries guidelines and acceptable behaviour in the workforce. Individual records of education were maintained for each staff member and were reviewed. Staff files evidenced reference checking and police vetting have been undertaken prior to employment.</p> <p>An orientation/induction programme is in place and all new staff are required to complete this within six weeks of employment. Staff performance is reviewed at the end of the orientation, goals are set and a performance appraisal is completed annually thereafter. Orientation for staff covers the essential components of the service provided and staff are required to complete 10 multichoice questions. Staff confirmed they have completed an orientation and confirmed their attendance at on-going in-service education and that their performance appraisals are current.</p> <p>The education coordinator/EN is responsible for oversight of the in-service education programme. The education programmes for 2017 and 2018 were reviewed and evidenced education is provided via online training or on site. External training is also attended. The local DHB provides opportunities for RNs to attend on-going education. Staff responsible for medication management have current medication competencies, however ongoing training has not been provided. Restraint competencies are current.</p>

		<p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme. The education coordinator/EN is the assessor for the programme.</p> <p>Annual practising certificates for all health professionals who require them were current. Staff files held current performance appraisals.</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>There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The facility manager and clinical nurse leader work full time and are rostered on-call after hours. Staff hours exceed the hours required in the DHB ARRC contract. Care staff interviewed reported there were adequate staff available and that they could complete the work allocated to them. Residents and families interviewed reported there was enough staff on duty that provided their relative with adequate care. Observations during this audit confirmed adequate staff cover was provided. The ORA suites are included in the facility footprint and rostering includes these suites.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p> <p>Electronic medication records are stored in a secure portal.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the facility manager (FM) or the clinical nurse leader (CNL). They are also provided with written information about the service and the admission process.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic</p>

		detail, assessments and signed admission agreements in accordance with contractual requirements.
<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, with an escort as appropriate. The service uses the WDHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the progress notes, is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative.</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 using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. (Refer also to criterion 1.2.7.5)</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were two residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and CNL and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive</p>

		<p>analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used and meet standing order guidelines.</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 food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in October 2018. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the Masterton City Council. A verification audit was undertaken on 31 May 2018, with the required corrective actions attended to and signed off 28 September 2018.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. The service continually has six to eight residents requiring meals to be moulid. An initiative to improve the visual appearance of moulid diets and make them more appealing to the residents is recognised as an area of continuous improvement.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>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>If a referral is received, but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNL. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Glenwood are initially assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>In all files reviewed, initial assessments are completed as per the policy and within 24 hours of admission. InterRAI assessments are completed within three weeks of admission and at least every six months unless the resident's condition changes. Interviews, documentation and observation verifies the RNs are familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels. Two specialist reviews, reviewing levels of care, were being undertaken on the day of audit.</p> <p>All residents have current interRAI assessments completed by one of five trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Nine care plans reviewed reflected the generalised support needs of residents. Two reflected the outcomes of the integrated assessment process and other relevant clinical information, in particular, the needs identified by the interRAI assessments. These care plans evidenced service integration with progress notes, activities notes and medical and allied health professional's notations which were clearly written, informative and relevant.</p> <p>Six of nine care plans reviewed did not evidence service integration or identify fully the required support the resident needed to achieve the desired outcomes, and this requires attention.</p> <p>In all nine files reviewed any change in care required was documented in progress notes 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</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care to residents was consistent with their needs and goals. 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 verbal handovers, progress notes and documentation. A range of</p>

meet their assessed needs and desired outcomes.		equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Two trained diversional therapists and an activities assistant provide the activities programme. In response to requests by residents and family members, activity resources were expanded to provide an activity programme that includes providing a formal activities programme over the weekend. This is an area recognised as one of continuous improvement.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal six-month care plan review. A range of van outings occur twice weekly, visiting areas, events or activities of interest requested by residents.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included a knitting group, a mah-jong group, a daily walking group, daily exercise programme, quizzes, activities, daily news updates and entertainment. Community groups, such as the intergenerational playgroup, which matches parents and their children with rest home residents, is hosted by Glenwood. Plunket groups, school and kapa haka groups visit Glenwood on a regular basis. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs, including the needs of younger residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the care provided. Examples of short-term care plans being consistently reviewed were sighted for infections and pain and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any</p>

		resulting changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, NP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to older persons' mental health services. Referrals are followed up on a regular basis by the RN or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes are in place for the management of waste and hazardous substances, including specific labelling requirements. Material safety data sheets provided by the chemical representative are available and accessible for staff. Chemicals are provided within in a closed system. Education on chemical safety has been provided. Staff confirmed this.</p> <p>Observations provided evidence that hazardous substances were correctly labelled, the containers were appropriate for the contents, including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled was provided and being used by staff, including gloves, aprons masks and visors. The laundry and cleaners demonstrated sound knowledge.</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>Glenwood Masonic Hospital is purpose built with wide passageways, large bedrooms with one and half width doors and good storage space for mobility aids. The six ORAs are within the facility and there are three suites incorporated into two of the wings. All rooms are dual purpose providing accommodation for either rest home or hospital level care.</p> <p>A current building warrant of fitness is displayed that expires on the 27 July 2019. Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for purpose. A maintenance person ensures a proactive and reactive maintenance programme is in place and buildings, plant and equipment are maintained to a high standard. Documentation reviewed, the maintenance person interviewed, and observation confirmed this. The testing and tagging of equipment and calibration of biomedical equipment was current.</p>

		<p>There are external areas available that are maintained, safe and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. The gardens are well maintained by a gardener who works one day a week. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, equipment is checked before use and they are competent to use it.</p> <p>Staff interviewed confirmed they know the process they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents interviewed confirmed they can move freely around the facility and that the accommodation meets their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There is a mix of bedrooms with their own full ensuites, full ensuites shared between two bedrooms and three bedrooms sharing a bathroom. There are adequate numbers of toilets throughout the facility including toilets for visitors. Residents and families interviewed reported that there were enough toilets and showers that are easy to access.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas with signage and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Bedrooms are large and there is lots of personal space provided to allow residents and staff to move around within the bedrooms safely. Most bedrooms are single accommodation and double bedrooms are used as single accommodation. Residents interviewed all spoke positively about their rooms and how easily they could move around in them. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheel chairs.</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</p>	FA	<p>There are numerous areas for residents to frequent for activities, dining and relaxing. Areas are easily accessed by residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents including those under the age of 65 and family confirmed this.</p>

their relaxation, activity, and dining needs.		
<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>	PA Low	<p>All laundry is washed and dried on site. The laundry person demonstrated good knowledge of the laundry processes. Residents and families reported the laundry was well managed and their clothes are returned in a timely manner.</p> <p>There are dedicated cleaners on site who have received appropriate training. Interview of a cleaner and training records confirmed this. The cleaners have lockable cupboards to store chemicals. All chemicals were in appropriately labelled containers. Residents and family stated the facility is cleaned to a high standard. Observations during the audit confirmed this. The FM stated they monitor the cleaning and laundry processes, however, there is no documented evidence that cleaning and laundry processes are monitored for effectiveness. The audit programme does not include cleaning and laundry audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The evacuation plan was approved by the New Zealand Fire Service on the 12 August 2010. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly with a copy sent to the New Zealand Fire Service and was last held on the 21 November 2018. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted, and all equipment had been checked within required timeframes. There is always at least one staff member on duty with a current first aid certificate.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQ's.</p> <p>There are call bells to alert staff. Call system audits are completed on a regular basis and residents and families reported staff responded promptly to call bells.</p> <p>The external doors are secured at 7pm and rechecked at 10pm. An after-hours bell is available for visitors to gain entry.</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</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Heating is provided by hot water radiators. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area. All resident areas are provided with natural light.</p>

<p>that is maintained at a safe and comfortable temperature.</p>		<p>Family and residents interviewed confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Glenwood provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level with input from the infection control coordinator (ICC). The infection control programme is reviewed annually.</p> <p>An RN is the designated ICC, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CNL, FM and the quality coordinator and tabled at the quality meeting (includes the IC committee), RN meeting and staff meeting. Infection control statistics are entered in the organisation's electronic database and results benchmarked with other facilities. The FM is informed of any IPC concern.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>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 ICC has appropriate skills, knowledge and qualifications and has undertaken external training in infection prevention and control as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available if needed. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements</p>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last two years and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>

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>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the ICC. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was a recent outbreak of influenza in August 2018.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections at Glenwood is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICC reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality, RN and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked with other aged care providers. The service had an influenza outbreak in August 2018 and a Norovirus outbreak in October 2017. The appropriate action was taken regarding these outbreaks.</p>
Standard 2.1.1: Restraint minimisation	FA	The service demonstrated that the use of restraint is actively minimised including the use of sensor mats, wedges and soft-landing mattresses. There were seven residents using restraint and four

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>residents using an enabler during the audit. The restraint coordinators are the education coordinator/EN and CNL and they demonstrated good knowledge relating to restraint minimisation. The restraint/enabler register is current and updated. The policies and procedures have definitions of restraints and enablers. Staff demonstrated knowledge about restraints and enablers and knew the difference between the two.</p> <p>The restraint approval group forms part of the quality meetings. Restraint is also an agenda item at staff meetings. Meeting minutes and staff confirmed this.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The use of restraint is approved by the restraint approval group prior to commencing the restraint, this includes the resident's GP. The GP completes three-monthly reviews of restraints in use. A signed job description for the restraint coordinator was evident in the staff member's files. Responsibilities of the restraint coordinators and approval group are clearly outlined.</p> <p>Restraint use is discussed in the quality and staff meetings. Staff confirmed their knowledge of the restraint processes.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Files of residents using restraint were reviewed. Restraint assessment forms were completed prior to commencing restraint. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. Long term care plans documented any risk and desired outcomes. Staff demonstrated knowledge in maintaining culturally safe practice when completing assessments for restraint use.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Restraint minimisation policies and procedures are accessible for all staff to read. Safe use of restraint is actively promoted. There is a current and updated restraint/enabler register. Care plans include any risk factors and ensures the resident's safety while using restraint. Staff demonstrated knowledge about restraints and strategies to promote resident safety while using restraint. There were no restraint-related injuries reported. Monitoring forms are in place for all residents who are using restraint and these were completed as required.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Residents using restraints and enablers are evaluated at least six-monthly and the resident's care plan six monthly. Consents and evaluation forms were signed by the GP and the resident's family/EPOA. The evaluation form includes (a) to (k) in the standard and the effectiveness of the restraint and the risk is documented in the long-term care plans. Staff confirmed their feedback was obtained by the restraint coordinators when evaluating the restraint in use. The restraint approval group evaluated the restraints in use at least six-monthly. Meeting minutes confirmed this.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint approval group is responsible for monitoring and reviewing restraint. Quality review of restraint is monitored through the internal audit programme. Identified issues are discussed at the quality and staff meetings as well as additional education that is required to support staff. This includes education relating to restraint and challenging behaviour. Staff demonstrated good knowledge relating to managing challenging behaviours. Use of restraint has decreased by two since the previous audit.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Education programmes for 2017 and 2018 were reviewed and the education coordinator/EN reported it is provided via online training or on-site sessions. Training is also provided at handover, especially when residents have specific issues. External training is provided including the DHB and hospice. Staff responsible for medication management have current medication competencies. Ongoing training has not been provided since 'Medimap' training in 2016.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme. The education coordinator/EN is the assessor for the programme.</p>	Ongoing medication training has not been provided to staff who are responsible for the management of medicines. The last session was held in 2016.	<p>Provide ongoing education at least annually for all staff involved in the management of medicines.</p> <p>30 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the</p>	PA Moderate	Six of nine care plans reviewed did not identify fully the required support the residents needed. Two were of residents with challenging behaviours. No behaviour management plan was in place despite behaviour monitoring, progress notes, verbal feedback and incident forms indicating the incidents of	Six of nine care plans reviewed did not have documentation	Provide evidence that all residents' care plans

<p>required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>challenging behaviours were frequent. Records indicated individual staff members managed behaviours in an appropriate manner, however no evidence of a co-ordinated approach, including a review of incidents/potential triggers was sighted. A review of these residents by a specialist was undertaken the day of audit.</p> <p>A resident admitted with a previous pressure injury, has developed an area of disruption, and is noted to have lost weight in the last three months. No planning is in place to identify the required support needed to manage this event.</p> <p>A resident with a recent wound has a wound management assessment and plan in the wound care folder, however the care plan identifies skin integrity intact.</p> <p>Two files of residents with chronic conditions, requiring interventions to detect possible deterioration and enable interventions before the resident experienced a level of discomfort, had no documentation identifying these interventions in the care plan (one of these hospital residents is referred to in 1.3.3).</p>	<p>that reflected fully the required support the residents needed to achieve the desired outcomes.</p>	<p>reflect fully the required support the resident needs to achieve the desired outcomes.</p> <p>90 days</p>
<p>Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>PA Low</p>	<p>Although the FM reported they keep a good watch on cleaning and laundry processes daily, there is no documented evidence to indicate that cleaning and laundry processes are monitored for effectiveness. The audit programme does not include cleaning and laundry audits. The quality coordinator developed and implemented audits for the cleaning and laundry processes while the auditors were on site.</p>	<p>Although the cleaning and laundry processes are checked daily, there is no documented evidence of ongoing monitoring.</p>	<p>Ensure there is documented evidence of monitoring of the cleaning and laundry processes.</p> <p>30 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	CI	<p>The service continually has six to eight residents requiring meals to be moulled. The residents receiving moulled diets are often not able to express either satisfaction or dissatisfaction with the meals. Kitchen staff, care staff, RNs and family however noted residents often pushed the food away without eating it. Residents showed no interest in the food when it was presented. Often staff mixed the moulled meal up, and the different food sources became indistinguishable. The service recognised the lack of appeal that moulled meals presented to residents and implemented an initiative to improve the visual appearance of moulled meals and present them in a manner that aligns the food with the item it represents.</p> <p>The system involved the purchasing of shapes, to enable the moulled food to be presented in a shape that was conducive to the foods original form (eg, sausage meat is presented in the shape of a sausage). This enables the resident to distinguish what the food is before eating it.</p> <p>An evaluation of the success of the initiative is evidenced by way of observation. Residents on moulled diets no longer push their food away. There is feedback from staff about the increase in the food consumption of residents</p>	Residents requiring moulled meals have them presented in a manner that is visually appealing and aligned with the food it represents to enable residents a more appealing nutritional experience and improved nutritional status for the residents. This has resulted in improved satisfaction (as observed by staff and family members), increased consumption and reduction in weight loss for this group of residents.

		on moulised diets, written feedback from families regarding how appealing the moulised meals are when served up, and reduction in residents' weight loss.	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Over the last two years, satisfaction survey results identified dissatisfaction with the activities programme being provided at Glenwood. The 2016-2017 survey identified only 64% of respondents were satisfied with the programme. Two areas of dissatisfaction were identified. One being confused residents becoming increasingly confused and disruptive in the late afternoons, and the other being an absence of activities in the weekend. The three activities staff at that time worked Monday to Friday, and activities finished at 3.30 pm. In response to the survey results, the activities programme was restructured in August 2017. The hours the activities programme operates was increased to enable activities to be provided later in the afternoons to attend to the needs of the confused residents. The programme was also extended to cover the weekends.</p> <p>Evaluation of the effectiveness of the changes implemented evidences an increase in satisfaction with the activities programme to 86% satisfaction. Improved satisfaction with the programme was supported by resident and family interviews.</p>	<p>The activities programme at Glenwood has been expanded beyond the usual Monday to Friday activities programme to provide a formalised activity programme seven days a week and extended to later in the afternoons to accommodate the needs of residents suffering from dementia. This has resulted in improved resident satisfaction.</p>

End of the report.