

# Heritage Lifecare (BPA) Limited - Glengarry Rest Home & 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>	Heritage Lifecare (BPA) Limited
<b>Premises audited:</b>	Glengarry Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 10 January 2019      End date: 11 January 2019
<b>Proposed changes to current services (if any):</b>	Reconfiguration of two rest home beds to dual purpose beds.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	34

# 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
	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

Glengarry Rest Home and Hospital provides rest home, hospital and dementia level care for up to 41 residents. The service is operated Heritage Lifecare (BPA) Limited and managed by a facility manager and a clinical services manager. Since the last audit the previous facility manager is now the clinical services manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board and included a review of a reconfiguration of two beds for dual purpose being either for rest home or hospital level care. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a nurse practitioner representing one of the local general practitioner services.

This audit identified two areas for improvement relating to hazardous substances and emergency management planning.

## 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 rights are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist healthcare providers to support best practice and meet resident's individual needs.

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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As a Heritage Lifecare (BPA) Limited (HLL) facility, Glengarry Rest Home and Hospital is guided by the organisation's business and quality and risk management plans. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The HLL quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements at a national and local level. Staff are involved and feedback is sought from residents and families. Adverse

events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

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

Residents' information is accurately recorded, securely stored and 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 efficiently managed with relevant information provided to the potential resident/family.

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

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs 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.

Some standards applicable to this service partially attained and of low risk.

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

Waste is well managed. Staff use protective equipment and clothing. Soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

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

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

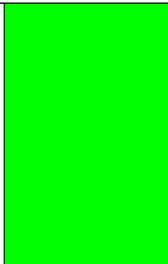
Standards applicable to this service fully attained.

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

Two enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests.

No restraints were in use. Staff demonstrated a sound knowledge and understanding of the restraint free philosophy and enabler processes.

## 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 a registered nurse and is currently overseen by the clinical services manager. The aim of the programme, reviewed annually, is to prevent and manage infections. Specialist infection prevention and control advice is accessed when needed.

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

Aged cares specific infection surveillance is undertaken and results are 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	43	0	2	0	0	0
<b>Criteria</b>	0	91	0	2	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Glengarry Lifecare (Glengarry Rest Home and Hospital) has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed 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 provided by the Health and Disability Advocacy Service, as was verified in training records. Caregivers were observed calling residents by their preferred name. The preferred name was also displayed on each resident's bedroom door.</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 understood 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</p>

		<p>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. There was clear evidence of enduring power of attorney (EPOA) arrangement in the home and in particular for residents in the dementia service. The NP was interviewed and had a good understanding of how to determine if a resident is competent in relation to decision making and as part of the informed consent process. 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. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The resident advocate attends residents' meetings to ensure residents are heard and that they understand discussions held. Rooms are able to be blessed after deceased residents leave the facility. The facility manager is highly respected by staff, family and residents and also advocates for the residents in this home. Staff were aware of how to access the National 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, their marae of choice and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. A facility van which has a hoist is available for outings and enables wheelchair bound residents to participate in group outings. The ability for residents to maintain links with family and the community has been enhanced at Glengarry Rest Home and Hospital, by the continued commitment of whanau and invited groups</p>

		<p>visiting the facility.</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 and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. A complaints/compliments box is sited prominently in the main reception area.</p> <p>The complaints register reviewed showed that five complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes required. Action plans showed any required follow up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. Complaints may be managed in conjunction with the clinical services manager and/or the regional operations manager. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</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 service has a resident advocate who attends the residents' meetings to ensure residents are kept informed. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</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 of Glengarry Rest Home and Hospital confirmed 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 and in discussion with families and the nurse practitioner (NP). All residents have a private room. The facility manager is the privacy officer. Training is accessible online and has been completed.</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 in 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>	<p>FA</p>	<p>There are 17 residents and at least 19 staff at Glengarry Rest Home and Hospital at the time of audit who identify as Māori. Interviews with residents and staff verified staff can support residents who identify as Māori to integrate their cultural values and beliefs. Every file reviewed of residents who identified as Maori had a Te Whare Tapa Wha assessment in their care plan. 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 organisation wide policy on Maori health plan consultation to guide the facility on the development of their own Maori health plan. The service has a Maori health plan developed with input from cultural advisors that includes a holistic Māori model of care. In this region alone there are 30 active marae operating. A</p>

		<p>kaumatua day is held on the last Tuesday of the month and residents attend for social, spiritual, cultural and health link reasons. The residents interviewed enjoyed this special day and links with their iwi and other Maori people. A Tikanga Best Practice flipchart was sighted in all nurses' offices.</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>Residents of Glengarry Rest Home and Hospital 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>
<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 and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A nurse practitioner (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>Glengarry Rest Home and Hospital encourages and promotes good practice through evidence-based policies and input from external specialist services and allied health professionals. For example, the</p>

		<p>hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians, services for older people, psycho-geriatrician and mental health services for older persons, and education of staff. The NP 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 for education. Education is provided internally, through in-service education by the clinical services manager (CSM), specialist speakers or access to on line learning. RNs can access training through the district health board (DHB), however generally use on line learning hubs or access to specialist advisors.</p> <p>Other examples of good practice observed at Glengarry Rest Home and Hospital included continuity of clinical expertise. There is a commitment to ensuring all staff maintain their competencies regarding meeting clinical expectations. The CSM and senior registered nurses assess all staff competencies. All care staff are medication competent or trained as checkers.</p> <p>There are a number of ongoing initiatives aimed at reducing the number of falls, minimising restraint/enabler use and improving the management and healing of wounds demonstrating a commitment to good practice and care delivered at Glengarry Rest Home and Hospital.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members from Glengarry Rest Home and Hospital stated they were kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the DHB when required. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to speak English and/or te reo Maori. Maori Health</p>

		Advisers are accessible and the contact numbers were available if needed.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Heritage Lifecare (BPA) Limited (HLL) have a standard business plan template which Glengarry Rest Home and Hospital (Glengarry) uses to identify site specific objectives and these are linked to the quality plan objectives. The HLL documents describe annual and longer term objectives and Glengarry manager's report against these. A sample of weekly and monthly reports were reviewed which go to support office and are monitored/reviewed by the regional operations manager and the quality team. The reports sighted showed adequate information to monitor performance is reported including financial performance, health and safety compliance, occupancy, staffing, emerging risks and clinical issues.</p> <p>The service has been managed since early December 2018 by a facility manager who is an enrolled nurse with extensive sector experience. She is currently being orientated to the role by the regional operations manager and the clinical services manager. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The regional operations manager, facility manager and clinical services manager confirmed knowledge of the sector, regulatory and reporting requirements.</p> <p>The facility holds contracts with Hawke's Bay District Health Board for Aged related residential care including hospital, rest home and dementia care and an E-engage contract as well as a Ministry of Health (MOH) contract for younger people with disabilities (YPD).</p> <p>On the day of audit 34 people were residing at Glengarry with nine of these people receiving services within the dementia unit known as Awhinatia. Four people were receiving services under the MOH YPD contract; one residing in the rest home and three in the hospital. There were nine residents receiving rest home level care and 12 people receiving hospital level care, one of these people was receiving respite care. The two beds now designated to be dual purpose were sighted and deemed appropriate for this.</p>

<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the facility manager is absent, the regional operations manager or the clinical services manager carries out all the required duties under delegated authority. During absences of key clinical staff, the clinical management is overseen by the regional operations manager or the organisation's quality and compliance team who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes audit activities, a document control system, management of incidents and complaints, a regular patient and family satisfaction survey, monitoring of outcomes, clinical incident monitoring including infections, falls, pressure injuries, skin tears, weight loss and medication errors.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the combined staff, quality, infection control, health and safety and restraint free meeting. Staff reported their involvement in quality and risk management activities through, meeting attendance, incident reporting, hazard identification and audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are required to be completed annually and regular feedback is provided to managers by the residents, visitors and family. Managers reported that actions are taken in response to any feedback as appropriate. Surveys are due to be performed as required by HLL in February and March 2019.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The regional operations manager described the processes for the</p>

		<p>identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager is familiar with the Health and Safety at Work Act (2015). The health and safety staff representative reported that she has attended the two day training and the organisation has implemented requirements.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>Staff document adverse and near miss events on an incident/ accident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner.</p> <p>Adverse event data is collated, analysed and reported via the organisation's central system managed by the clinical and quality team.</p> <p>The facility manager and regional operations manager described essential notification reporting requirements, including for pressure injuries and that these are escalated to the GM clinical and quality, who is responsible for ensuring notifications occur. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. An electronic system is used for the recruitment process and includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation requires the completion of orientation and competency workbooks which include all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period. The facility manager is currently completing the HLL managers' orientation package.</p>

		Continuing education is planned on an annual basis, including mandatory training requirements. All RNs are required to have first aid training and caregivers interviewed reported they also have this certification. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. An external assessor is currently being resourced for the programme. Staff working in the dementia care area have completed the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	HLL provides a documented process which is implemented at Glengarry for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, and the clinical service manager reported she lives within three minutes of the facility and staff are able to contact the Wairoa hospital acute ward RN if required. Staff reported that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of eight weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.  There are two RNs who are interRAI trained and assessed as competent, another is in training and a fourth commences training later this month. The final two RNs, including the clinical services manager, are booked to commence training in March of this year.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded,	FA	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

<p>current, confidential, and accessible when required.</p>		<p>health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP/NP 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 an electronic cataloguing system.</p> <p>Residents' records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<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 CSM and FM. They are also provided with comprehensive written information about the company, 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 details, assessments and signed admission agreements in accordance with contractual requirements. A specialist referral was confirmed for each individual resident in the dementia service and the enduring power of attorney (EPOA) documentation evidenced consent for admission.</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>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a resident recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident</p>

		<p>reported being kept well informed during the transfer of their relative. Any residents requiring transfer to HBDHB are transferred to Wairoa Hospital first for review, stabilisation and then transferred as required to the secondary facility. Mode of transport (road and/or air) is decided upon depending on the condition of the resident and weather at the time.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<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.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an 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 were met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administer medications (inhalers) at the time of audit. Appropriate processes were in place to ensure this can be managed safely.</p>

		<p>Medication errors are reported to the RN and CSM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders (nurse-initiated medications) are no longer used.</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>	<p>FA</p>	<p>The food service is provided on site by a cook who has worked for 16 years at the facility and two experienced kitchen hands who relieve the cook and cover the weekends. The food service is managed in line with recognised nutritional guidelines for older people. The four weekly menu plans follow summer and winter patterns and were reviewed by a qualified dietitian in June 2018. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place, and due to expire 26 June 2019. A verification audit of the food control plan was undertaken and any recommendations were actioned.</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. Food is taken to the service areas in hot boxes and served to the residents.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction are 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</p>

		the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.
<p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></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 CSM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents of Glengarry Rest Home and Hospital are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, nutrition, oral, risk 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. A physiotherapist is employed by Glengarry Rest Home and Hospital, to provide physiotherapy services as needed. Residents are assessed by a physiotherapist on referral basis. An ongoing plan is put in place as indicated by assessment findings.</p> <p>Interviews, documentation and observation verified 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.</p> <p>All residents had current interRAI assessments completed by one of two trained interRAI assessors on site. One registered nurse is in training, one is booked to complete the training 26 January 2019 and two are booked for March 2019 to complete the relevant training. InterRAI</p>

		assessments are used to inform the care plan.
<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>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed. Behaviour management plans were sighted for individual residents in the dementia service which were well documented.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<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 care provided to residents was consistent with their needs, goals and the plan of care.</p> <p>The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The NP 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, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a trained diversional therapist (DT) who qualified in 2011. Activities are provided five days a week, with additional events organised to occur over the weekend. Each day, group and one on one sessions are provided. The first few hours of the day are spent providing activities in the dementia care service and then the DT moves to the rest home/hospital areas of service delivery to continue the programme which is displayed in every resident's individual room and on the notice boards in the rest home hospital and dementia care service.</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-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included daily exercise sessions, visits from local schools and kapa haka groups, visiting entertainers, quiz sessions, daily news updates and regular van outings. The activities programme is discussed at the minuted residents' monthly meetings and indicated residents' input is sought and responded to. The resident advocate attends these resident meetings. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> <p>The activities provided for the residents in the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. A separate programme is developed and implemented to cover the 24-hour period and to meet the needs of the residents.</p> <p>There are currently four under 65-year olds two are under 65 and two are now over 65, who can access activities which meet the diverse needs of someone younger. The DT spends additional time enabling the residents with one to one activities, 'skype' calls to friends overseas and access to community events. Staff cover one day or the other in the weekends to take residents out to community events including church on Sunday each week.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>Residents' 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</p>

<p>comprehensive and timely manner.</p>		<p>the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short-term care plans being consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. The service has three main medical practice providers, and residents may choose their own medical practitioner. The nurse practitioner interviewed is well supported in her role by the medical staff at each practice. If the need for other non-urgent services are indicated or requested, the GP/NP or CSM sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the older persons' mental health services, orthopaedic, eye clinic, laboratory referrals and/or to other allied health providers. Referrals are followed up on a regular basis by the CSM or the GP/NP. 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 Wairoa Hospital accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>PA Low</p>	<p>Staff follow HLL documented processes for the management of waste and infectious and hazardous substances. Signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are used and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>Bulk chemicals used by the previous owner were stored in an external</p>

		<p>shed and within the facility although they are no longer used. This added to the pressure on storage spaces and resulted in inappropriate items being stored together.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</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 June 2019 is publicly 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 including the van hoist, is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Residents were safe and independence is promoted. An induction loop to enhance the hearing experience of residents using hearing aids is in place in the large lounge used by all residents. The secure dementia unit provided a safe, homelike environment which enabled meaningful walking around and through a well-kept garden, with two access doors.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting, with multiple easy access doors.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance is required and any requests are appropriately actioned. Residents were happy with the environment.</p> <p>No changes are required to the building warrant of fitness for the reconfiguration.</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 bathroom and toilet facilities throughout Glengarry. This includes separate toilet and shower rooms. One dual purpose room has an ensuite with a toilet and shower.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to</p>

		promote residents' independence.
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow Glengarry staff and residents to move around within their bedrooms safely. All bedrooms provide single accommodation.</p> <p>All of the rooms to be designated as dual purpose are larger than the seven rest home only bedrooms. All dual purpose rooms have adequate door width and room size as required for hospital level rooms.</p> <p>Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available in-door and out-doors for residents to engage in activities. The dining and lounge areas are particularly spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required in their own rooms or the garden.</p> <p>Furniture is appropriate to the setting and residents' needs.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></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>Laundry is undertaken on site in a dedicated laundry and by family members if requested. Some clothes are hung out on an external washing line. Dedicated laundry staff, housekeeping staff and caregivers demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents and family interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team who have received appropriate training. The managers indicated the laundry and cleaning staff are to undertake the New Zealand Qualifications Authority Certificate in Cleaning (Level 2). Cleaning chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p>

		<p>Cleaning and laundry processes are monitored regularly by the facility manager, from residents, family and staff feedback and through internal audit activity.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>HLL provides policies and guidelines for emergency planning, preparation and response for each facility to use in the development of site specific plans. Instructions are displayed and known to staff. HLL disaster and civil defence planning guides direct facilities in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. Glengarry is the Emergency Response Centre for their side of the river as the Wairoa hospital is on the other side of the river; however, Glengarry is yet to ensure their emergency plan is relevant to the Wairoa setting.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 21 May 2012. A trial evacuation takes place six-monthly with an external expert providing oversight and feedback, the most recent being on 30 July 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 food, water, blankets, mobile phones and gas BBQ's were sighted and meet the requirements for the 34 residents. The organisation is currently in discussion with the Hawke's Bay District Health Board as to how Glengarry can be used as an additional storage place for the DHB for supplies such as water and other supplies in the event of a civil emergency. Water storage tanks are located in the garden and emergency lighting is regularly tested.</p> <p>Call bells alert staff through an electronic system to residents requiring assistance. Call bells are positioned throughout the facility in all rooms and communal areas and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time depending on the season and staff do security checks at night. Night patrols are done in the area by a local</p>

		<p>voluntary group.</p> <p>No changes are required to the fire evacuation scheme for the reconfiguration.</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>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately.</p> <p>Rooms have natural light, most have opening external windows and two rooms that are off the conservatory have skylights and windows that open into the conservatory. The residents and family in these two rooms have indicated their satisfaction with the rooms.</p> <p>Heating is provided by heat pumps in the communal areas and ceiling heaters in residents' rooms.</p> <p>Areas were being cooled with fans on the day of audit and were well ventilated throughout the audit. Residents and families 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>	FA	<p>Glengarry Rest Home and Hospital provides a managed environment that minimises the risk of infection to residents, staff and visitors through 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 CSM. The infection control programme and manual are reviewed annually.</p> <p>The Clinical Services Manager (CSM) oversees the infection prevention and control programme. A registered nurse is the designated infection control officer, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the quality/risk meeting. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisation's national quality and compliance manager is informed of any IPC concern.</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>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>	FA	<p>The infection control officer (ICO) has appropriate skills, knowledge and qualifications for the role. The ICO who was not interviewed has recently been appointed to this role. The CSM has attended training in infection prevention and control and is currently overseeing the programme until the RN has completed the relevant training, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from an external advisory company is also available if additional support/information is required. The ICO has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The CSM confirmed the availability of resources to support the programme and any outbreak of an infection. There have been no outbreaks of infection since the last audit.</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 and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year 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>
Standard 3.4: Education	FA	Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the infection control officer, the CSM and registered nurses. 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 increase in urinary tract infections, and it was found to be related to a decrease in fluids. Signage is displayed in all clinical areas about maintaining hydration especially in the summer months.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICO 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 and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>HLL policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers.</p>

<p>minimised.</p>		<p>Restraint use has been eliminated at Glengarry, with alternatives being explored and used instead. Glengarry managers stated the facility has been restraint free for many years and they gave examples of measures taken to ensure resident safety without the use of restraint for people unable to consent to the use of an enabler.</p> <p>The restraint coordinator role is performed by the clinical service manager who provides support and oversight for enabler use and maintenance of a restraint free facility. She demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>All RNs are required to be restraint free competent and evidenced of this was in staff files reviewed.</p> <p>On the day of audit, no residents were using restraints and two residents were using bedrails as enablers. These were used voluntarily at their request. A similar process is followed for the use of enablers at Glengarry that is described in HLL policy for restraint use. This was evident on review of the residents' files, and from interviews with managers and staff. The enabler use has been regularly reviewed for both residents using bedrails, as required by HLL policy and the enabler register included documented goals for each person.</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 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.</p>	PA Low	The bulk chemicals no longer used by the previous owner have not been disposed of and are stored inappropriately in an external shed and within the facility. Whilst no immediate risk to staff or residents is evident, best practice requires minimal quantities of hazardous substances to be held at any time and unused chemicals held by the previous provider are to be disposed of safely. There is no evidence an approved handler has reviewed the hazardous substances storage at the facility.	Current legislation requires safe, secure storage and disposal of hazardous substances. The bulk chemicals no longer used at the facility by the previous provider need to be removed appropriately.	<p>Remove the unused chemicals and review hazardous substance storage at Glengarry to ensure compliance with relevant legislation.</p> <p>30 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to</p>	PA Low	The Glengarry emergency plan is written using the HLL template and does not reflect the specific local requirements of the facility, for example no gas turn off and the facility's role	The Glengarry Emergency Management Plan does not reflect local conditions and Glengarry's role as a potential	Revise the Glengarry emergency plan to accurately reflect Glengarry's role within

<p>identified emergency and security situations. This shall include fire safety and emergency procedures.</p>		<p>in the DHB's Major Incident Plan.</p>	<p>Emergency Response Centre have not been included in Glengarry's documents which guide staff.</p>	<p>the DHB Emergency Response Plan.</p> <p>90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.