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

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Heritage Lifecare (BPA) Limited

**Premises audited:** Glengarry Rest Home & Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 25 January 2022 End date: 26 January 2022

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 32

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Heritage Lifecare (BPA) Limited - Glengarry Rest Home & Hospital (Glengarry) provides care for up to 41 residents requiring aged residential rest home, secure dementia and hospital level care.

This certification audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of policies, procedures, residents’ and staff files, observations and interviews with residents, families, managers and staff.

There are ten areas identified as requiring improvement at this audit. These related to monitoring progress towards achieving business goals/objectives, the frequent changes in management, ensuring meetings that include quality and risk issues are occurring as scheduled with records available and review of the hazard register, corrective action planning including ensuring neurological monitoring occurs following unwitnessed falls, aspects of staff training, and staffing and skill mix. Timeliness of care planning and ensuring residents are consistently assessed as suitable for three monthly general practitioner reviews, care coordination, detail of care plans available, and the activities programme also require improvement.

Residents and family members interviewed were satisfied with most aspects of care and services provided.

## 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 at Glengarry Lifecare. 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 in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Care for residents who identify as Māori 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 family/whānau is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

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

Residents and family members are informed of the complaints process. Complaints are investigated and responded to in a timely manner.

## Organisational management

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| --- | --- | --- |
| 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 medium or high risk and/or unattained and of low risk. |

The organisation's philosophy, mission and vision statement are documented, along with goals. The previous care home manager and the clinical services manager resigned in late 2021. There have been a number of interim management arrangements in place with a roaming clinical services manager now covering both management roles. A new care home manager starts early February 2022.

The quality management systems include an internal audit programme, complaints management, incident/accident reporting, and hazard and risk management. Policies and procedures are developed nationally by Heritage Lifecare Limited and made available to staff.

Recruitment processes align with current accepted standards. New staff have an orientation relevant to their role. Ongoing education is provided. Applicable staff and contractors maintain current annual practising certificates.

There is a registered nurse on duty at all times. Since 22 November 2021, the roster has included registered nurses employed by the district health board.

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

## Continuum of service delivery

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Glengarry Lifecare works closely with the local Needs Assessment and Service Co-ordination Service. There were no vacancies at the time of audit as Glengarry is currently not accepting any new admissions. However, when a vacancy does occur, relevant information is provided to the potential resident/family/whānau to facilitate the admission.

Residents’ needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets assist in guiding continuity of care.

Care plans are individualised. Residents and family/whānau 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 activity programme is provided by an activities assistant and overseen by a diversional therapist. 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. Registered nurses and senior care staff administer medications, 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 and their family/whānau verified overall satisfaction with meals.

## Safe and appropriate environment

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| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substance.

There are documented emergency management response processes, and designated supplies for use in emergency are available. Fire drills are conducted, most recently in January 2022.

The building has a current building warrant of fitness. The fire evacuation plan has been updated since the last audit and approved by the New Zealand Fire Service. There have been no other significant changes to the facility since the previous audit.

The facilities meet residents’ needs and provide furnishings and equipment that are regularly maintained and updated. Bedroom areas allow residents to move around with or without assistance. There are adequate toilet, bathing and hand washing facilities. Employed staff are responsible for cleaning and laundry services.

The lounge and dining areas meet residents' relaxation, activity and dining needs. Appropriate external areas are available for residents’ use, including a secure courtyard area for residents living in the secure dementia unit.

The facility is kept at a suitable temperature and is appropriately ventilated. Appropriate security systems are in place.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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 restraint minimisation. One resident had restraints in use at the time of audit. A process of restraint related assessment, approval, monitoring and regular review occurs.

One resident was using an enabler. Use of enablers is voluntary for the safety of residents in response to individual requests.

Staff were able to details their responsibilities when caring for residents with restraints and enablers in use.

## Infection prevention and control

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

The infection prevention and control programme, led by an appropriately trained infection control nurse, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the organisation’s infection control advisor and the infection control nurse at the Hawke’s Bay 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, with data analysed, trended, and benchmarked. 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)** |
| **Standards** | 0 | 43 | 0 | 0 | 7 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 1 | 9 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Glengarry Lifecare (Glengarry) has policies, procedures, and processes in place 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 from May 2021. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files reviewed showed that informed consent had been gained appropriately using the organisation’s standard consent form, including for photographs, outings, invasive procedures, and collection of health information.  Files reviewed of residents in the secure unit had an activated enduring power of attorney (EPOA) in place. Consents and admission documents were signed by the EPOA.  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.  Staff were observed to gain consent for day-to-day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents and their family members/whānau were given a copy of the Code, which also includes information on the Advocacy Service. Additional brochures on the advocacy service were available at reception. Family/whānau members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff were aware of how to access the Advocacy Service.  A resident appointed advocate resides at Glengarry. Residents/whānau freely discuss any concerns with the advocate, who takes these concerns to management if requested to. An interview with the advocate, verified that the advocate is familiar with the role and responsibilities that go with the role and is aware where additional support can be gained if needed. The resident verbalised residents at Glengarry are very happy. Any past concerns, which are few, when discussed with the manager have been resolved promptly and to the resident’s satisfaction. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family/whānau and the community within the constraints imposed by Covid-19 restrictions. Visiting at Glengarry is limited and by appointment. All visitors are required to wear a mask and show a vaccination certificate. All visitors are temperature checked and required to fill in a disclosure statement. Family/whānau wanting to take residents out, are requested to talk with the manager and ensure residents only mix with family/whānau that have been vaccinated. Family/whānau are kept informed regarding any changes and ongoing updates by phone or by email.  Family/whānau members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff and were kept well informed. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints management 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. Residents and family members interviewed advised they have been provided with information on the complaints process and had not made any complaints. One family member had expressed a concern about a garment that shrunk during laundering, and noted they had been promptly reimbursed for this. The resident who is also the resident advocate advised if any concerns have been raised these have been promptly addressed by management.  The complaints register reviewed showed that eight complaints have been received since 15 January 2021. The actions taken, through to an agreed resolution, were clearly documented and completed within applicable timeframes for the sampled complaints, with one exception. A complaint from the HDC on 8 December 2021 was closed by the HDC with a request that Glengarry liaise with the complainant directly. This complaint remain open as the Glengarry management team have been unable to obtain the complainants contact details. This information is being sought. The care home manager (CHM) is responsible for complaints management and follow-up. Staff in the national support office assists with any significant and/or external complaint review and response.  All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from the District Health Board, Ministry of Health or Accident Compensation Corporation since the last audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents and family/whānau interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with staff. The Code is displayed in common areas around the facility. Information on the advocacy services, how to make a complaint and feedback forms are on display at the front entrance. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families/whānau confirmed that services at Glengarry are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families/whānau. All residents have a private room.  Residents are encouraged to maintain their independence. Participation in community activities, regular outings to the local shops or areas of interest, participation in clubs of their choosing and visitors entering the facility, has been limited due to ongoing Covid-19 restrictions. Each resident’s care plan included documentation related to the resident’s abilities, and strategies to maximise independence.  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.  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. The annual training plan includes training on abuse and neglect; however, this has not been provided in 2021 (refer criterion 1.2.7.5). |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There are a high percentage of residents and staff at Glengarry who identify as Māori. Observations, documentation, and interviews verified that Glengarry supports residents, staff and visitors 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. The resident appointed advocate identifies as Māori and assists management staff and residents in maintaining a Māori perspective throughout the day-to-day operations of the facility. There is a current Māori health plan developed with input from cultural advisers. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents and family/whānau 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 2019 resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met, and this supported those individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family/whānau members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe.  The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their individual employment contract. 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. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | 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, physiotherapist, wound care specialist, Hawke’s Bay District Health Board (HBDHB) services for older people. The general practitioner (GP) who provides services to Glengarry residents works at the local hospital. The GP visits Glengarry monthly on a regular basis, however, often cannot attend if an acute visit is required. In this situation the resident is transferred to the local hospital to receive services. On the days of audit, the GP was unavailable for interview as they were on leave.  A resident with a stage three pressure injury, and co-morbidities that predisposed the resident to high risk for deterioration and compromised healing ability, has a wound that has improved and nearly healed. A section 31 notification of a facility acquired unstageable pressure was made to the Ministry of Health, as was a request for input by the wound care nurse specialist. Photo’s evidence the wound at that time. Prior to the wound care nurse seeing the wound it had nearly healed with the wound care management provided by Glengarry.  Thirty percent of care staff have been at Glengarry for greater than ten years. Others have been there just over a year or recently employed. Staff movement from the region is high. All but two care staff have level three and four qualifications in care of the older adult. All staff but two, who work in the secure unit, have verification sighted that they are qualified in care of residents with dementia (refer criterion 1.2.7.5).  Other examples of good practice observed during the audit included a commitment to providing an environment that encompasses the needs of Māori. An environment where care staff were laughing, singing, and interacting with residents in a loving and supportive manner. Residents, family/whānau had high praise for the professionalism and quality care provided by the staff. Staff’s commitment to resident care and Glengarry at a time of ongoing changes, disruption and uncertainty for their future and security was evident. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family/whānau members stated they were kept well informed about any changes to their own or their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family/whānau input into the care process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services can be accessed via the HBDHB or the courts. Staff reported interpreter services were rarely required due to all present residents being able to speak English or te reo Māori. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Moderate | The vision, values and scope of services are developed by Heritage Lifecare Limited (HLL), and are communicated to staff, along with the behaviour/conduct expected of staff.  A business and strategic plan for 2021 was developed for Glengarry Rest Home and Hospital (Glengarry). The formal process to monitor Glengarry’s progress achieving goals has not occurred since June/July 2021. There have been frequent changes in the management team since September 2021. The current HLL relief clinical services manager is also now the interim care home manager. However, these arrangements have not been sufficiently communicated, including to HealthCERT.  There have been difficulties recruiting registered nurses. In addition to the relief CSM, there are currently two casual RNs working at Glengarry employed by HLL. Heritage Lifecare Limited has been working with the DHB in response to this challenge with the DHB providing RNs to help cover shifts for the period 22 November 2021 until 6 March 2022 (refer to 1.2.8.1). A review is in progress, with community consultation, to determine the scope of aged related residential care (ARRC) services that will continue to be provided at Glengarry. While this process is underway, new admissions are not being accepted with the exception of a recent resident requiring short term care. The service has relocated several hospital level residents to other care facilities where this has been agreed to by the resident and family.  The facility holds contracts with the Hawke’s Bay District Health Board for aged related residential care including hospital, rest home, dementia care and respite care. In addition, they have a Ministry of Health (MoH) contract for younger people with disabilities (YPD) and long-term support chronic health (LTSCH). On the day of the audit, 32 people were residing at Glengarry with eight of these people receiving services in the dementia unit known as Awhinatia. Fifteen people were receiving hospital level care, including two people under the MoH YPD contract, one person under LTSCH and twelve people receiving aged related residential care. There are nine people receiving rest home level care including one respite.  There are a total of 25 dual purpose beds. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the CHM’s absence, the regional manager is currently responsible for the oversight of services with the support of one of the Glengarry casual RNs, who has held previous leadership roles in this care home. The regional manager is a registered nurse, with current interRAI competency. Staff advise the regional manager is regularly on site, including while the CHM has been on annual leave. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | The organisation has a planned quality and risk management system. This includes audit activities, a document control system, reporting of incidents/hazards and complaints, a resident satisfaction survey, and clinical incident monitoring including infections, falls, pressure injuries/ulcers, skin tears and bruises, near miss events, resident behaviours causing concern, significant weight loss, infections, restraint use and medication errors. The clinical indicator data is reported monthly within HLL with analysis noted on themes and trends in comparison with the previous month.  There are a range of meetings that are intended to occur as part of the process of ensuring key quality and risk issues are being communicated with staff, and to provide a forum for residents to provide feedback. A number of these meetings are not occurring as intended, and when held, the summary of discussions have not included all applicable components. The meeting minutes have not been made available to those not present at the meeting.  While corrective action plans are being developed, this was are not consistent. Monitoring that the required actions have been undertaken is also not consistently occurring. This includes neurological monitoring of residents post unwitnessed falls.  The hazard register has not been reviewed since September 2020, although staff have reported new hazards, and these have been managed well.  Policies reviewed covered necessary aspects of service and contractual requirements including reference to the interRAI Long Term Care Facility (LTCF) assessment and process. Policies are based on best practice and developed by HLL nationally and distributed to Glengarry along with a summary of any changes made. Efforts are ongoing nationally to review the documents that are overdue and progress is being made. In addition, policies and procedures are in the process of undergoing review to align with the new Ngā Paerewa Standards. All relevant policies for infection control management with regard to the current pandemic Covid-19 were sighted and updated regularly. The document control system facilitates the review, approval, distribution and removal of obsolete documents.  The CHM described the processes for the identification, monitoring, review and reporting of risks and development of any mitigation strategies if required. The facility manager is familiar with the Health and Safety at Work Act (2015). There is a Glengarry risk management plan which details potential risk, actions required and by whom. The regional manager stated risks related to the scope of services provided, the RN shortage and current staffing arrangements are well known to HLL executive team who have been involved with meetings with the DHB and MOH in relation to these concerns. The Glengarry management team advised there are currently remote meetings occurring with representatives from the DHB weekly. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on an incident/accident form. This is provided to the RN on duty for review and immediate follow-up. The CHM is entering the data onto an electronic resident management system for analysis, and inclusion in the HLL benchmarking programme. The electronic entry of incident data has been occurring for several months as the initial step in the journey for Glengarry to transition to an all-electronic resident record.  A sample of incidents forms reviewed showed that these were fully completed. Incidents were investigated and immediate actions taken to address the issues. However resident short term care plans were not consistently developed or long-term care plans reviewed where required (refer to the areas for improvement raised in 1.3.3.3, 1.3.3.4 and 1.3.5.2). Whilst corrective actions are required, the actions are not always sufficiency documented, including for neurological monitoring following unwitnessed falls. This is included in the area for improvement raised in 1.2.3.8.  Adverse event data is collated, analysed and reported via the organisation’s central system managed by the clinical and quality team.  The regional manager and CHM described essential notification reporting requirements, including for pressure injuries, and that these are escalated to support office, who is responsible for ensuring notifications occur. This included multiple section 31 notifications related to insufficient registered nurse staffing, a pressure injury, a fire alarm, three residents with gastroenteritis symptoms, eight residents with respiratory symptoms, a power outage, absconding, and a resident smoking in bed. While some section 31 notifications have occurred of changes in management, this did not include notification of the current management arrangements. This is included in the area for improvement raised in 1.2.1.3. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | Human resources management policies, procedures and processes are based on good employment practice and relevant legislation. The recruitment process includes staff completing an application form, interviews, 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 maintained.  Staff orientation requires the completion of orientation and competencies relevant to the role being undertaken. Staff, including a DHB RN interviewed, reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and annual performance review.  Continuing education is planned and provided. Records are not available to verify staff training/attendance for abuse and neglect and fire safety, and that all staff working in the secure dementia unit have a New Zealand industry approved qualification in dementia care as required to meet the ARRC contract requirements. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | There is a significant shortage of registered nurses employed by Glengarry, with only two casual RNs employed and the CHM. Registered nurses have been provided by the DHB since 22 November 2021 to ensure there is one registered nurse on duty at all times, for the care and safety of residents. This arrangement is said to be in place until 6 March 2022 while HLL reviews the scope of services that will be provided on site (refer to 1.2.1). None of the Glengarry employed RNs have current interRAI competency. All interRAI assessments are currently being completed by the regional manager (refer to 1.2.1.3, 1.3.3.3, 1.3.3.4, and 1.3.5.2). The staffing matrix/framework was not available for review. There are also challenges covering unplanned care staff leave, the weekend cleaning role is vacant and no cover is available, and the activities staff member is at time redeployed to other roles (refer to 1.3.7.1). |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | 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 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.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.  Electronic medication records are stored in a secure portal. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Glengarry is currently not admitting any new residents to the facility due to staffing shortages and potential changes in services that may be offered in the future.  Residents previously admitted entered the service when their required level of care had been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their family/whānau were encouraged to visit the facility prior to admission and meet with the care home manager (CHM) or the clinical services manager (CSM). They were provided with written information about the service and the admission process. Residents admitted to the secure unit were required to have a specialist’s authorisation for placement and an activated EPOA in place.  Family/whānau 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 detail, assessments, and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the HBDHB ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident, and the family. At the time of transition between services, appropriate information, including medication records and the care plan is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed during the transfer of their relative. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  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 components they are responsible for.  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.  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.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted included 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.  There was one resident who self-administers inhaler medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.  Medication errors are reported to the RN and CHM 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.  Standing orders are not used at Glengarry. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The 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 was reviewed by a qualified dietitian in December 2021. Recommendations made at that time have been implemented.  An up-to-date food control plan is in place at Glengarry. A verification audit of that food control plan was undertaken by the Wairoa District Council on 16 September 2021. Four areas requiring corrective action were identified. These were addressed and signed off on 14 October 2021. The food control plan was verified till 18 March 2023.  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.  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.  Evidence of resident satisfaction with meals was verified by resident and family/whānau interviews and satisfaction surveys. The residents advocate stated that areas of dissatisfaction with meals are promptly responded to by the cook. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.  Residents in the secure unit have access to food at any time night or day. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | Glengarry, at the time of the audit, was declining entry to all new residents due to staffing shortages and potential changes to the services being offered in the future. If a referral is received or an enquiry made the family/whānau are advised of the present situation and advised to contact the local NASC. Family/whānau are supported to find an appropriate alternative.  Several hospital residents, with the consent of the resident and their family/whānau, are being assisted to move out of Glengarry to other sites around the country. In the situations that this has occurred, this has enabled residents to be closer to family/whānau. An interview with a resident who was transferring out of Glengarry, after being there for a while, verified the resident was happy to be moving to be closer to family. Several other hospital residents were leaving Glengarry within the next few days to also move and be closer to family/whānau.  If the needs of a present resident at Glengarry changes 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. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | On admission, residents of Glengarry 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.  In all files reviewed, initial assessments were completed as per the policy and within 24 hours of admission. InterRAI assessments were completed within three weeks of admission and at least six monthly unless the resident’s condition changes. Interviews, documentation, and observation verified the RN carrying out the assessments is familiar with requirement for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing need levels.  All residents at Glengarry have current interRAI assessments completed by one trained interRAI assessor, who is the organisation’s regional manager (RM) covering the region. InterRAI assessments are not being consistently used to inform the care plan (refer to 1.3.3 and 1.3.5.2). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Care plans reviewed at Glengarry were consumer focussed, however they did not consistently reflect the support needs of each resident, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were not always reflected in the care plans reviewed. Evidence verified there is no regular RN onsite at Glengarry competent, other than the RM (refer to 1.2.8.1) to do the interRAI assessments. The RM therefore does the interRAI assessments when they are due and is reliant on another RN to document the plan of care the resident requires. RN hours are covered by casual RNs, and temporary RNs supplied by the HBDHB. These RNs are employed to ensure safe clinical practice on the floor and do not complete care plans. They are unfamiliar with the residents interRAI assessment findings, and specific individualised needs.  Care plans at Glengarry did not evidence service integration with progress notes, activities notes and medical and allied health professional’s notations. Any change in care required was documented in the progress notes and verbally passed on to relevant staff, however there was often no documentation in the care plan or short-term care plans that documented the planned approach. Two files reviewed in the secure unit, verified the residents have a behaviour management plan in place that addresses specific behavioural challenges and strategies to manage these. However, these have not been reviewed in the past six months (refer to 1.3.3.3). These are areas requiring attention.  Residents and family/whānau did, however, report participation and involvement in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations, and interviews verified the care provided 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. Care staff confirmed that care was provided as per verbal orders from the CHM and RN and based on the resident’s prior care provision, not as per the documentation in the care plans. Refer to 1.3.5.2.  A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate | The activities programme is provided on site by an activities assistant who is in the process of completing the diversional therapy training. The programme provided is overseen by a diversional therapist from another facility, who signs off (approves) the programme. The activities assistant works five days a week, 8.30 am - 4.30 pm, however on a Thursday and Friday may be called into relieve for the cook. The CHM says if this occurs, a caregiver (if available), provides the residents with the activities planned for that day.  The activity’s assistant reported that the programme is run in the secure unit in the morning and in the hospital rest home area in the afternoon. Residents from the secure unit, attend the afternoon sessions where able.  A social assessment and history are undertaken when residents are admitted, 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 in the activity plan review every six months. However, an activity plan identifying residents’ individual diversional, motivational, and recreational needs over a 24 hour period was not present in sampled resident files in the secure dementia unit. There were no additional activities available to meet the needs of the two residents under 65 years. These areas require attention.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents’ goals, ordinary patterns of life and include normal community activities, when permitted under the Covid-19 restrictions. Individual, group activities and regular events are offered. Examples included’ sit and be fit’, daily news updates, quizzes, singing, kaumatua day, movies, word games, van outings, one on one sessions, walks, news, waiata, and pampering time. The activities programme is reportedly to be discussed at the residents’ monthly meetings. However, these have not been held recently. They were last held in the rest home and hospital in July 2021. There were no records sighted of meetings in the secure unit until January 2022 (refer criterion 1.2.3.5).  An interview with the resident’s advocate verbalised the activities provided in the rest home and hospital were not available every day, but when they were they were fun and enjoyable.  Results from resident and family/whānau satisfaction surveys, demonstrated some degree of dissatisfaction with the range of activities being provided at Glengarry. The activities programme is not displayed in the secure dementia unit, and during the two days of audit, there was no evidence of activities being provided in the secure unit by the activities assistant. This is an area requiring improvement. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. The RN documents evaluations. Where progress is different from expected, the service responds by initiating changes to the plan of care. (Refer to 1.3.3 and 1.3.5). Examples are sighted of short-term care plans being consistently reviewed for infections, pain and wound care and progress evaluated as clinically indicated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | 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 is indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files. 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. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow HLL documented processes for the management of waste and infectious and hazardous substances. Signage is displayed as necessary. Material data sheets were available and used by staff interviewed and staff knew how to manage any chemical spillage should this occur. Personal protective equipment (PPE) is readily available to staff, family and residents. Supplies were sighted and were appropriate especially with regard to Covid-19 pandemic management. Staff and visitors were observed using the required PPE correctly. The Glengarry hazardous substance register was updated in November 2021.  Applicable staff were provided with training on safe handling of chemicals in May 2021. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility is single level. The building warrant of fitness (expiry date 16 June 2022) was displayed in the main entrance. Appropriate systems are in place to ensure the residents` physical environment and facilities are fit for their purpose and are maintained. Maintenance requests are actioned in a timely manner as per request records sighted. The testing and tagging of electrical equipment and calibration of bio medical equipment was current and confirmed in documentation reviewed, interviews with maintenance personal and observation of the environment. The temperature of the hot water is regularly tested and is within the required range. The environment was hazard free, residents were safe, and independence promoted.  There is a proactive maintenance plan, which is being implemented. The maintenance and garden coordinator is also a health and safety representative.  The facility vehicle has a current registration and warrant of fitness. The vehicle hoist is reported to have been recently serviced.  External areas are safely maintained and are appropriate to the resident groups and settings. There is a secure garden area for residents in the secure dementia unit. The gate has been replaced since the last audit resulting in a new fire evacuation plan being developed and subsequently approved by the New Zealand Fire Service. A plantar box located near one of the internal fences in the secure dementia unit was removed/dismantled on the first day of audit.  Residents and family members are happy the facility is maintained and homely. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | Hand basins are present in sampled residents’ bedrooms. There are adequate numbers of accessible communal showers and toilet facilities throughout the facility including designated staff and visitor toilets. There is one bedroom with a full ensuite. There are occupied/vacant signs for use in bathroom and toilet areas. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents’ independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All residents’ bedrooms are single occupancy. The rooms all contained space for the residents’ personal possessions, and use of mobility devices, if required. Residents were sighted mobilising inside the care home independently, including while using a mobility aid.  The staff interviewed advised there is sufficient space for the residents to mobilise, including when assistance was required. The residents and family members interviewed confirmed this. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | All residents have single occupancy rooms. There are a number of other areas that residents can use for activities or to meet with family and friends. This includes the lounge and two dining rooms in the rest home / hospital and the lounge /dining room in the secure dementia unit. The residents and family members interviewed confirmed that there was sufficient space available for residents and support persons to use if required in addition to the residents’ bedrooms.  There are safe appropriate furnished external areas for residents’ use. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Policies detail how the cleaning and laundry services are to be provided. Laundry services are undertaken on site. This includes the washing of residents’ personal clothing. Residents’ personal clothing is washed, folded and returned.  The residents and family members interviewed noted the rest home is usually kept clean and tidy, although occasionally some areas of dust were noted. Audits of cleaning and laundry services were undertaken as scheduled and reports demonstrated compliance with the service requirements. Residents and family members interviewed were satisfied were satisfied with the laundry services, with one family member noted they had been reimbursed for a garment that was damaged during laundry processes.  Chemicals are stored in designated secure cupboards/rooms which are locked. A cleaner and laundry staff interviewed confirmed being provided with training on the safe handling of chemicals and had written instructions readily available on the use of products and required cleaning processes/activities. Records verifying this education was present in applicable staff files sampled.  Instructions for managing emergency exposures to chemicals was readily available to staff. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The fire evacuation plan sighted was approved by the New Zealand Fire Service (NZFS) in a letter dated 11 February 2021. The fire evacuation plans was updated after changes were made to the external gate in the secure dementia unit courtyard. A list is maintained detailing residents’ names and room number and the level of support they require in the event of an emergency.  The most recent fire evacuation education was conducted on 21 January 2022. Records are not available to demonstrate that all staff have completed ongoing fire safety training. This is included in the area for improvement raised at criterion 1.2.7.5.  Policy documents and a wall mounted flip chart provides guidance for staff on responding to civil emergency and disaster events, and training was last provided in January 2021.  Review of the staff files and training records verified that there is at least one staff member on duty at all times with a current first aid certificate.  There are sufficient supplies available of dry food, lighting, torches and batteries, and other clinical supplies for use in an emergency. A portable gas cooker is available along with spare blankets. A 2000 litre water tank is onsite that contained sufficient supplies for use in emergency. The water is changed six monthly. There are additional supplies of bottled water available. Emergency supplies are checked and rotated as required.  Call bells are present in the bathrooms and residents’ bedrooms. They alert via an audible sound, and notification through to a centralised panel. Two call bells tested at random were fully functioning. The functioning of call bells is monitored monthly via internal audit.  Visitors entering the building are directed via signage to come to the main entrance. Visitor restrictions have been in place as required by the National Covid-19 alert levels, although are now reoccurring in a planned manner from 11 am to 3 pm daily. No concerns were expressed by residents or the family members interviewed about security arrangements. Caregivers advise they are required to visually check each resident at night and lock the doors/windows around 7-8 pm and again on shift handover to the night staff. Caregivers advised regular checks of residents are undertaken throughout each shift. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents` rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is via heat pumps and ceiling panel/tile heating. The thermostat can be adjusted for temperature control.  The facility was warm and well ventilated throughout the audit and residents and families confirmed the facilities were maintained at a comfortable temperature. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | Glengarry 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 nurse (ICN)/CHM and the RM (the organisation’s IPC advisor). The infection control programme and manual are reviewed annually.  The CHM at Glengarry is the designated ICN, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the RM and to staff via handover or notifications to staff in the staff room. Infection control statistics are entered in the organisation’s electronic database and benchmarked within the organisation’s other facilities. The organisation’s general manager is informed of any IPC concern.  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. Entry to the facility also requires an appointment, a vaccination pass, a mask, temperature monitoring and the filling out of a disclosure statement regarding health status. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell, in addition to protocols to be implemented in the event of exposure to a Covid-19 contact or place of interest. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICN has appropriate skills, knowledge, and qualifications for the role, however, has been in this role for only a short time and is being assisted by the RM. The ICN has undertaken training in infection prevention and control, as verified in training records sighted. Well-established local networks with the infection control team at the HBDHB are available in addition to support from the organisation’s ICP advisor. The ICN has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICN confirmed the availability of resources and PPE to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The 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.  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. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | 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 suitably qualified RNs and the ICN. 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 community Covid-19 cases and training on Covid-19 preparedness was provided.  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. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | 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 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.  The ICN and RM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via handover and handouts displayed in the staffroom. 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.  A respiratory outbreak occurred at Glengarry in August 2021 and involved eight residents. Public health and the HBDHB were informed. A comprehensive analysis was undertaken with no areas requiring corrective action identified.  A good supply of personal protective equipment is available. Glengarry has processes in place to manage the risks imposed by Covid-19. In the event of the region having to go into lockdown, there are pandemic supplies to support them for six weeks. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CHM is currently the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. The CHM demonstrated a sound understanding of the organisation`s policies, procedures and practice and the role and responsibilities involved.  On the day of the audit, one resident (hospital level of care) was using a restraint. Bedside rails were the form of restraint in use. The resident had previously been using bedrails as an enabler; however these were changed to a restraint in December 2021 when the resident was identified as having progressed to being unable to ask for the bedrails to be lowered. One other resident was using an enabler (bedrail). Enablers are the least restrictive and are only used voluntarily at a resident’s request.  Restraint is used as a last resort when alternatives have been explored. This was evident on review of records reviewed, and from interviews with staff and managers. The use of restraint is included in the clinical indicator data monitored and reported on monthly. |
| Standard 2.2.1: Restraint approval and processes  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. | FA | The restraint approval process involves the general practitioner, the CHM who is the restraint coordinator, and a family/resident representative/EPOA, who are responsible for the approval of the use of restraints.  A review of the applicable resident’s records and interviews with a registered nurse, the CHM, the regional manager, and other care staff confirmed that there were clear lines of accountability and that the restraint currently in use has been approved. The overall use of restraints is being monitored and reported monthly at restraint minimisation meetings. The regional manager has been attending the restraint minimisation committee meetings in the last three applicable meeting minutes sighted (October to December 2021).  Evidence of family/whānau/EPOA involvement in the decision making was on record in the applicable resident’s records sampled. However, use of a restraint was not included in the applicable resident’s individualised plan of care. This is included in the area for improvement raised in criterion 1.3.5.2. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented and included all requirements of the Standard. The CHM/restraint coordinator undertakes the initial assessment with the input from the resident`s family/whānau/EPOA. The individual resident`s general practitioner is involved in the final decision on the safety of the use of the restraint.  The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and any associated risks. The restraint use was to help ensure the resident`s safety and security. Completed assessments were sighted in the applicable resident’s sampled record. A family member was not able to be interviewed. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraint is minimised as much as possible, and the CHM/restraint coordinator and care staff discussed how alternatives to restraints are discussed and implemented with staff and family members, including the use of sensor mats and/or low beds. When restraints are in use, frequent monitoring (at least two hourly) occurs to ensure the resident remains safe. There was evidence of regular monitoring. Any adverse events/incidents are required to be reported and followed up via the incident reporting system and included in the interRAI re-assessments and care planning process.  Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. A restraint register is maintained by the CHM/restraint coordinator, updated as required, and reviewed/discussed at each monthly restraint minimisation meeting, and staff meetings. The register was reviewed and detailed the resident currently using a restraint. Another register details residents using an enabler.  Staff received training in the organisation`s policy and procedures and restraint minimisation practices during orientation and as a component of the ongoing education programme. All staff are noted to have completed the annual training requirements in May 2021 as verified in the December 2021 restraint minimisation meeting. The restraint related education records for 2021 were also present in applicable staffs’ sampled files. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Review of a resident’s records showed that the individual use of restraints was reviewed and evaluated during the care plan and interRAI reviews, the restraint minimisation committee meetings and at staff meetings. This was verified by care staff and the CHM interviewed. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The CHM/restraint coordinator undertakes a regular review of the resident with restraint use, most recently in January 2022, and a regular restraint audit (last completed 1 December 2021). These processes included the restraint used and type, whether all alternatives to restraint have been considered, the effectiveness of the restraint use, and the competency of staff, the appropriateness of restraint/enabler education and any feedback from the doctor, staff and families.  Any changes to policies, guidelines, staff education/training and processes are implemented if indicated. Data reviewed, minutes and interview with the CHM/restraint coordinator confirmed that minimisation of the use of restraint is a priority/focus. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | A business plan for Glengarry Rest Home and Hospital was sighted for 2021. This is reported to be developed in alignment with the Heritage Lifecare Limited (HLL) overarching business plan. The 2022 document is reported to be under development.  The business plan details the goals and objectives for the service and includes a formal process to review and document progress on a quarterly basis. The reviews of progress for the first two quarters in 2021 have occurred, but not since June 2021 in the records available for review.  The care home manager (CHM) is required to submit monthly reports that enable monitoring of key aspects of service delivery. Due to the changes in the management team (refer to 1.2.1.3), this has not occurred since July 2021, although there are other communication processes occurring including verbally and via email. | As a result of the changes in personnel in management roles, the quarterly review of progress in achieving the goals/objectives as detailed in the Glengarry Lifecare business and strategic plan has not occurred since June 2021.  Although there is regular verbal communication occurring, the formal monthly facility managers’ report has not been completed since July 2021. | Ensure the required processes are implemented to monitor progress towards achieving goals.  90 days |
| Criterion 1.2.1.3  The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services. | PA Moderate | There has been a national restructure of some roles in late 2021. This included the regional quality manager roles and the regional operation manager roles. The previous HLL ’head of clinical’ has moved to another management role. The director of quality, compliance and risk has been in the role approximately 12 months.  The Glengarry regional manager was initially employed by HLL in August 2021 as a regional quality manager covering nine care homes. Since December 2021, these roles have merged and are now titled as regional manager. The regional manager is new to HLL, however is very experienced and has previously worked in other aged related residential care services in senior management and clinical roles. The regional manager is a registered nurse and has current interRAI competency. The regional manager is still orientating to the operations manager component of the role, with the senior leadership team of HLL meeting for two days during the week of audit. The regional manager has oversight of four care homes under the new structure. The regional manager is currently undertaking all interRAI assessments of residents at Glengarry as there are no other trained registered nurses employed. Refer to the areas for improvement raised in 1.2.8.1 and 1.3.3.4.  The previous care home manager resigned on 17 December 2021, however prior to this has been on leave since 18 October 2021, with the exception of approximately one week on site during this time. A new care home manager has been recruited and will commence early February 2022.  The previous clinical services manager (CSM) resigned on the 10 September 2021. Relief clinical services managers assisted on site until 18 October 2021 when a relief CSM was appointed more permanently to this role for a fixed duration. The relief CSM has worked for HLL for many years including in management roles. The relief CSM was subsequently also allocated the care home manager responsibilities from 17 December 2021 and is referred to as the CHM in this report. The changes in management have not been effectively communicated. An updated interim position description and employment contract was not developed nor HealthCERT notified as an essential notification (Section 31). Refer to 1.2.4.  For the period 10 September to the end of December 2021 there have been 11 different interim clinical services or care home manager arrangements in place at Glengarry. Staff interviewed noted the changes created uncertainty with some variation in what each manager expected, expressed concerns about what the outcome of the HLL scope/service review will be and the prospective impact on employment security. | There has been restructuring of roles and responsibilities at a national level and changes in personnel in key roles. Staff at Glengarry report the multiple changes in care home management team since 10 September 2021 have created uncertainty.  The Heritage Lifecare relief clinical services manager (CSM) is reported to also be the care home manager since 17 December 2021. The CSM does not have a job description or employment agreement for this expanded role. This change was not reported to HealthCERT as a section 31 notification. | Ensure the role and responsibilities of the manager(s) are clearly identified in position description and employment agreement documents.  Ensure HealthCERT is informed of changes in the person undertaking applicable management roles in a timely manner.  90 days |
| Criterion 1.2.3.5  Key components of service delivery shall be explicitly linked to the quality management system. | PA Moderate | There are a number of meetings that are expected to occur regularly on site. This includes staff meetings, quality meetings, and health and safety meetings which are intended to occur monthly. Templates are available for the recording of minutes and detail the topics to be included in each meeting. The records for the two staff meetings held since 3 November 2021 did not include all required aspects. These minutes have yet to be typed and/or distributed to staff for their review. Care staff interviewed advised they are informed of resident falls/infections and other incidents and concerns/issues during shift handover.  The health and safety committee has not met since July 2021. The quality committee has had one meeting since July 2021, with meetings intended to occur 4-6 weekly. The quality meeting that was held occurred in January 2022 and included discussion on relevant quality and risk issues.  Resident meetings have not occurred on a regular basis since July 2021 for rest home residents. Only one meeting has occurred for residents and family since July 2021. This meeting occurred in the secure dementia unit in January 2022.  There is a detailed hazard register for Glengarry. The document sighted has not been reviewed since September 2020. | The various meetings utilised to communicate key quality and risk information to staff and obtain feedback from residents are not occurring regularly including health and safety, staff meetings and resident meetings. When staff meetings occur, they have not included all applicable topics and the minutes have not been made available for staff. | Ensure staff meetings, health and safety meetings and resident meetings occur in a regular scheduled manner, and the minutes include all relevant components and are made available for staff and residents in a timely manner.  Ensure the hazard register is reviewed regularly.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Corrective action plans are developed when improvements have been identified following internal audits. There is inconsistent evidence that there is follow-up to ensure the required actions have been undertaken and have been effective. For example, there was no evidence of follow-up of the results of staff satisfaction survey (2019/20), management of behaviours that challenge audit (July 2021), and resident satisfaction survey (mid 2021). Similar feedback related to the activities programme were reported by residents and family members at audit. While some actions have been taken in response to incidents, short term care plans are not consistently developed, or long terms care plans updated (refer to 1.3.5.2) as required.  The CHM identified that staff are not consistently undertaking neurological monitoring post unwitnessed falls as required by policy. While some actions have been undertaken to address this issue, a corrective action plan has not been documented. It was observed during audit that neurological observations have not occurred as required by policy in four out of four residents’ files sampled who had unwitnessed falls. Refer to 1.3.3. | While staff can identify/verbalise corrective actions taken in response to incidents or audits, these are not consistently documented, or reviewed for effectiveness.  Neurological monitoring is not occurring as required by policy following unwitnessed resident falls. | Ensure where improvements are required, the required actions are documented, implemented, and monitored for effectiveness.  Ensure neurological monitoring is consistently occurring as required by policy post unwitnessed resident falls.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | There is an annual training plan for 2021 and 2022, and staff education has been provided. The topics included restraint minimisation (May 2021), falls management and neurological monitoring and chemical safety (May 2021), first aid (April 2021), infection prevention and control/standard precautions, use of personal protective equipment (PPE) end of life care, and manual handling (December 2021), medicine management (July 2021), nutrition and hydration and recognising pain and promoting comfort (August 2021). Due to the impact of Covid-19, not all planned training has been able to occur in the last 12 months as planned. The training on abuse and neglect has not occurred in 2021, and it was unclear from available records when this topic was last provided.  Records of in-service attendance, via session signing sheets, are maintained. The administrator has recently developed an electronic spreadsheet to also record all staff training. Although six monthly fire drills are occurring, records have not been retained to demonstrate the names of staff that participated in the fire safety or fire drill training in 2021/2022 to date.  Records are not available to demonstrate that two applicable care staff working in the secure dementia unit have completed an industry approved qualification in dementia care. One of the caregivers is noted to have completed an overseas training programme, however this does not have New Zealand qualification equivalency.  Applicable staff have current medicine competency. | Records are not available to demonstrate that staff have completed abuse and neglect training or fire safety training in 2021/2022 to date, although a fire drill most occurred most recently in January 2021.  Records are not available to demonstrate that two care staff that have been working in the secure dementia unit for over 18 months have complete an industry approved qualification in dementia care. | Ensure all staff complete regular training on abuse and neglect and fire safety procedures and records of attendance are maintained.  Ensure staff working in the secure dementia unit have completed an industry approved qualification in dementia care within 18 months of employment and records are retained to demonstrate this.  90 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | Assorted documents including the roster and time sheet policy provides principals for rostering and staffing. The document refers to a ‘safe rostering tool and occupancy’. The management team (regional manager and CHM) interviewed advised this tool has been withdrawn by HLL and an equivalent other document was not able to be provided for review. The management team reported there is a template roster that records the shifts that are required to be filled and overall staffing needs and utilisation is monitored via the dashboard key performance indicators (KPIs).  There are two casual RNs employed by Glengarry. One is working three shifts a week and one is working three half shifts a week. The DHB sends through a weekly summary of the shifts they will provide a registered nurse for. This ranged from between nine and 16 RN shifts provided each week in the random records sighted. Some of the DHB RNs are working regular or set shifts at Glengarry. The DHB RN interviewed has been enjoying the role and notes working regular shifts enabling the RN to develop a greater familiarity with the residents and care home routine. The Glengarry casual nurses or the CHM (in addition to the management role), covers shifts as necessary to ensure there is an RN on duty at all times. Staff advise the CHM is working long hours. A new CHM has been employed and will commence at Glengarry on 4 February 2022. The regional manager is also regularly on site and is currently undertaking all the resident interRAI assessments when required. A new experienced aged care RN has been employed commencing 8 February 2022.  There has been some recent turnover in care staff. Staff interviewed noted there was uncertainty about what services will be provided on site and some staff including those requiring job security have sought other employment opportunities. This has resulted in a number of gaps on the caregiving roster, in particular when staff have called in for unplanned leave. In the two weeks roster sighted from 10 January to 23 January 2021, there are six and eight caregiver shifts respectively each week that were not covered. There are 11 caregiver shifts that require filling before the next care staff roster is released. An extensive range of recruitment activities continue to be undertaken to fill the vacant roles. Care staff advised they work together to ensure the care needs of the residents are met and confirmed that the registered nurses provide assistance and support as and when required. Refer to standard 1.1.8 for information on caregivers’ qualifications/experience.  A review of the roster demonstrated that the service works to have four caregivers working in the rest home and hospital in the morning and three in the afternoon (with one staff member working a shorter shift both morning and afternoon), and two caregivers on at night. There is also another caregiver rostered on duty each shift in the secure dementia unit. There is an RN on duty at all times. On occasions this is the CHM.  A cleaner works Monday to Friday 8 am to 2.30 pm. The weekend cleaner role has been vacant since mid-December 2021, and cover has not been available. The management team advised in addition to the weekend cleaner, there are a minimum of three registered nurses and four caregiver shifts currently being recruited.  The activities assistant works weekdays 8.30 am to 4.30 pm, however also covers some shifts in the kitchen when required. A lack of meaningful activities occurring is raised in criterion 1.3.7.1.  The maintenance and gardening coordinator, and an administrator work full time weekdays. Laundry services are provided daily (including weekends) from 8 am to 2 pm.  Two staff share the cook role over seven days 8 am to 4.30 pm, and there is a kitchen assistant on duty covering specified morning and afternoon/evening hours.  Residents and family interviewed spoke highly of the staff employed at Glengarry and with the exception of the activities programme, confirmed their needs were being met.  There is a staff member on duty at all times with a current first aid certificate. | There is a significant RN shortage, with RNs being provided by DHB until 6 March 2022. Caregiver shifts are not always able to be covered including for unplanned staff absences. There has not been a weekend cleaner since mid-December 2021.  The previous formula for calculating staffing requirements is no longer in use. The management team were unsure of how staffing hours are calculated although data is being regularly monitored and reported by dashboard KPI reports. | All the applicable organisation’s documents that provide the framework for staffing and skill mix are available and ensure these requirements are implemented for all roles. Continue recruitment activities to fill vacant positions.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | All residents initial care plans and initial assessments, including the interRAI assessment, have been carried out in a timely manner. However, in five out of the nine files reviewed, the long-term care plans were not completed or updated in a timely manner. Two hospital residents admitted greater than three months ago did not have long-term care plans in their files. One hospital resident’s long-term care plan had not been updated within the last six months.  Two residents’ files reviewed in the secure unit had behavioural management plans that had not been reviewed within the last eight months, and their long-term care plans had not been updated within the last six months or as their needs changed. Both these residents also had no evidence the GP had deemed them stable and able to be reviewed three monthly rather than monthly.  There are no employed RNs at Glengarry who are interRAI competent. The organisation’s regional manager undertakes the assessments. This person does not update the care plans and there is no permanent RN employed, other than the care home manager to keep the care plan documentation up to date, and reflective of residents’ needs. | Care planning is not consistently provided within the required timeframes to safely meet the residents’ needs | Provide evidence that long term care plans are developed within 21 days of admission and reviewed at least six monthly or as a resident’s needs change.  Ensure behavioural management plans are reviewed at least six monthly and reflect resident’s needs.  Ensure all residents are assessed by the GP monthly, unless the GP verifies that they are stable and able to be reviewed three monthly.  Ensure residents’ care is planned within timeframes that safely meets the needs of the resident.  90 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Moderate | Systems are in place at Glengarry to promote continuity of care, such as detailed progress notes, a verbal handover at the start of each shift, and written handover sheets; however, the frequent management changes (refer criterion 1.2.1.3), shortage of RNs and care staff (refer criterion 1.2.8.1), the use of temporary staff from other facilities who are not familiar with residents, and care plans not being up to date (refer criterion 1.3.5.2), compromises the ability to provide continuity care with a coordinated approach. | The present service is not coordinated in a manner that promotes continuity of care to residents. | Provide evidence systems are in place to ensure coordinated care that promotes continuity is provided to residents.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Six of nine residents’ care plans reviewed were not reflective of the residents’ individual needs.  A resident without a long-term care plan in place was using a restraint and had no plan in place around the management of the restraint. Additional documentation, observations and interviews verified the use of restraint was being managed appropriately.  A resident was noted in incident reports to have wandered away a couple of times and was found near the site. There is no documentation in place to manage this risk. However, family members and care staff were aware, and the resident was being closely observed. The resident had two recent unwitnessed falls, an incident form was sighted, and family were informed, however no neurological observations had been taken. An interview with the CHM, verified this is an area identified as requiring attention (refer criterion 1.2.3.8).  Short term care plans had in some cases not been implemented to address short term problems (refer to three residents reviewed using tracer methodology in criterion 1.3.3). In addition to these examples, short-term care plans were also not in place to manage a resident’s weight loss, the nursing responsibility to monitor the effects of a change in a resident’s medication, and the request by the GP in May 2021 to monitor a resident’s blood sugar levels to ensure they remain within the specified range. Evidence was sighted of these care requirements being addressed; however, there was no documentation in place identifying these interventions are required to support a planned approach to resident care. | Residents care plans do not always describe the required support the resident needs to meet the desired outcomes. | Provide evidence that care plans describe fully the required support the resident needs to achieve the desired outcomes.  90 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | All residents’ files reviewed had an activities assessment and activities plan in place that was reviewed every six months. However, an activity plan identifying residents’ individual diversional, motivational, and recreational needs over a 24 hour period, with consideration of the resident’s previous lifestyle patterns were not in use in the secure dementia unit.  An activities programme was not on display in the secure unit, nor was there evidence that the activities planned for that day were taking place. On the first day of audit, residents in the secure unit were observed to be watching the television all morning. In the afternoon some of those residents attended the afternoon activity session in the rest home/hospital. On the second day of audit, the caregiver in the secure unit, was observed to be playing cards with the residents.  No other activities were observed to be occurring in the rest home or hospital prior to 1.30 pm on the second day. Two of nine hospital and rest home residents interviewed expressed concern regarding the lack of activities and minimal van outings. Three of six family members reported minimal activities are provided at Glengarry. The CHM and the RM interviewed supported this. The last resident satisfaction survey included feedback from at least 25% of respondents expressing some dissatisfaction about the activities programme being provided at Glengarry (refer to 1.2.3.8). There were no additional activities available to meet the needs of the two residents under 65 years. | Activities that are meaningful to residents are planned, however they are not verified as being provided.  A care plan identifying residents’ individual diversional, motivational, and recreational needs over a 24 hour period, with consideration of the resident’s previous lifestyle patterns were not in use in the secure dementia unit. | Ensure a care plan identifying residents’ individual diversional, motivational, and recreational needs over a 24 hour period, with consideration of the resident’s previous lifestyle patterns are in use for residents in the secure dementia unit.  Provide evidence that activities in the rest home, hospital, the secure dementia unit and for those under 65 years, are planned and provided to maintain residents’ skills, strengths, and interests.  90 days |

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

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

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

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

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End of the report.