Whitehaven Healthcare Limited - Glendale Retirement Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Whitehaven Healthcare Limited
Premises audited:	Glendale Retirement Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 December 2018 End date: 6 December 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 33

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Glendale Retirement Home is a privately-owned care facility and is certified to provide rest home level care for up to 33 residents. On the day of audit there were 33 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

Glendale has a business quality and risk management plan. Goals and objectives of the business are identified and reviewed annually. The manager has a long history with Glendale – having been the previous owner. The manager has been in this role for four years. The manager is supported by a quality assurance coordinator and a registered nurse.

Residents and family members interviewed praised the service for the support provided.

The service has been awarded two continuous improvement ratings around activities and falls prevention.

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 staff at Glendale Retirement Home ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff are familiar with processes to ensure informed consent. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

Performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction of the service. The business plan and quality plan have goals documented. There are policies and procedures to ensure support and care to residents with rest home level needs. This includes a documented quality and risk management programme that includes analysis of data.

Ongoing training is provided and there is a training plan developed and implemented for 2018. Rosters and interviews indicated sufficient staff that are appropriately skilled with flexibility of staffing around client's needs.

Continuum of service delivery

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

There is an admission package available prior to or on entry to the service. The registered nurse is responsible for each stage of service provision. The registered nurse assesses, develops care plans and reviews each resident's needs, outcomes and goals at least six monthly. Care plans demonstrated service integration and included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect current guidelines. Registered nurses and senior carers responsible for administration of medication complete annual education and medication competencies. The medicine charts had been reviewed by the general practitioner at least three monthly.

An activity coordinator implements the activity programme for the residents. The programme includes community visitors, outings and activities that meet the individual and group recreational preferences for the residents.

Residents' food preferences and dietary requirements are identified at admission. All meals and baking are cooked on site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Dislikes and special dietary requirement are met.

Safe and appropriate environment

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

There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely. There is a current building warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised. Some resident rooms have ensuites. There are adequate communal shower/toilet facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Systems and supplies are in place for essential, emergency and security services. There is a staff member on duty at all times with a current first aid certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.

Glendale Retirement Home actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There are no residents using enablers or restraint.

Infection prevention and control

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

Infections are reported by staff and residents and monitored through the infection control surveillance programme by the infection control officer (the nurse manager). There are infection prevention and control policies, procedures and a monitoring system in place. Training of staff and information to residents is delivered regularly. Infections are monitored and evaluated for trends.

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	1	44	0	0	0	0	0
Criteria	2	91	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

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	Discussions with staff (three caregivers, one cook, the registered nurse, the manager and quality assurance coordinator) confirmed their familiarity with the Code. Five residents and four family members interviewed confirmed that the services being provided are in line with the Health and Disability Services Consumers' Rights (the Code).
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	There are established informed consent policies/procedures and advanced directives. General written consents are obtained on admission. Specific consents are obtained for specific procedures such as influenza vaccine. All six resident files including one younger person contained signed general consents. Resuscitation status had been signed appropriately. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers (CG) interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Four family and six residents (including one YPD) interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.

		Six resident files reviewed had signed admission agreements.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Contact numbers for advocacy services are included in the policy, in the resident information folder and in advocacy pamphlets that are available around the facility. Discussions with residents confirmed that the service provides opportunities for the family/EPOA to be involved in decisions. All staff interviewed were familiar with the role of advocacy. One resident within the facility currently utilises the advocacy service.
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 confirmed that visiting can occur at any time. Key people involved in the resident's life have been documented in the resident files. Residents verified that they have been supported and encouraged to remain involved in the community. The residents on YPD contracts are engaged in a range of community activities.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are available at the front foyer. The residents interviewed were aware of the complaints process and to whom they should direct complaints. The service has had only had one documented complaint since 2015. Residents and relatives interviewed were aware of the complaints procedure and how to access forms.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed confirmed they are well-informed about the Code. Surveys and direct communication with management provide the opportunity to raise concerns. Advocacy and Code of Rights information is included in the information pack. The code of rights, advocacy service, information on how to make a complaint, and complaint forms are on display at the front door foyer of the facility. Large code of rights posters are visible within the facility.
Standard 1.1.3: Independence,	FA	Staff are able to describe the procedures for maintaining confidentiality of resident records, resident's

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.		privacy and dignity. Orientation includes reading of policies around privacy, respect and dignity. All staff support the promotion of independence of the residents. The in-service schedule has sessions on resident rights, confidentiality and privacy, dignity, choice and independence. Residents are supported to attend church services held within the facility or attend church services in the community if they wish. Residents reported that they are able to choose to engage in activities and access community resources. The two residents on younger persons disability contracts (YPD) are encouraged to maintain their personal gender, sexual, cultural religious and spiritual identity. There is an abuse and neglect policy and staff education around this has occurred.
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	The service has a Māori heath plan and an individual's values and beliefs policy which includes cultural safety and awareness. There were no residents who identified as Māori at the time of audit. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau, and how they cared for a resident recently. The service has access to the mobile Māori wellness service for assistance or advice when required. Staff are aware of the need to respond appropriately to maintain cultural safety. Staff have had training around cultural safety.
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	Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Staff have received training on cultural awareness.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The staff employment process includes the signing of a staff code of conduct form and house rules document on commencement of employment. Job descriptions include responsibilities of the position and ethics, advocacy and legal issues. The orientation programme provided to staff on induction includes an emphasis on provision of dignity, privacy, and respecting all ethnic and cultural differences. Professional boundaries training is included in the communication training sessions.
Standard 1.1.8: Good Practice Consumers receive services of an	FA	The service meets the individualised needs of residents who have been assessed as requiring rest home level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include the requirement

appropriate standard.		to attend orientation and ongoing in-service training. Combined quality/staff meetings are conducted on a monthly basis. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the manager and registered nurse. All caregivers are supported to complete level three Careerforce.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated their relatives are informed of changes in health status and incidents/accidents. This was confirmed on ten incident forms reviewed. Relatives interviewed also confirmed they are kept well informed. Residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings have occurred monthly, and management have an open-door policy. The residents stated that the manager and quality assurance coordinator are on-site daily. All residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There are two residents who are sight impaired who have access to the blind foundation service. The service has policies and procedures available for access to interpreter services for residents (and their family).
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Glendale Retirement Home is a privately-owned service that provides rest home level care for up to 33 residents. On the day of audit there were 33 rest home residents including two residents on YPD contracts. Glendale has a business quality and risk management plan. Plans, aims and ambitions of the business are resident focused and are reviewed annually. Progress towards achievement of goals is documented. The manager has a long history with Glendale – having been the previous owner. The manager has been in the role since February 2015 for the current owner and is supported by an experienced registered nurse (RN) and the quality assurance coordinator. The manager maintains weekly contacts with the owner and completes a three-monthly report to include: quality information; staff training; occupancy data; and other business-related issues. The manager has completed at least eight hours of professional development including Careerforce levels three and four and assessor training.

Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During the temporary absence of the manager, the registered nurse fulfils this role.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The quality assurance coordinator facilitates the quality programme and ensures the internal audit schedules are implemented. Corrective action plans are developed, implemented and signed off when service shortfalls are identified. Quality improvement processes are in place to capture and manage non-compliances. They include (but not limited to) internal audits, hazard management, risk management, incident and accident and infection control data collection. Quality improvement data is discussed at monthly combined quality/staff meetings. Resident meetings have been held monthly. One resident on a YPD contract is actively involved in planning the activities for the month, and menu reviews. Policies and procedures have been accessed from an external agency. These have been adapted to suit the needs of the facility. If there have been changes in legislations, the agency has sent through updates. There are policies and procedures that are relevant to the service type offered, these are reviewed and updated at least yearly or sooner if there is a change in guidelines or industry best practice. There is a current risk management plan which is reviewed on an annual basis. Hazards are identified, managed and documented on the hazard register. There is a designated health and safety officer who has attended external training specific to health and safety. Health and safety issues are discussed at monthly health and safety meetings and the quality/staff meeting with action plans documented to address issues raised. Falls prevention strategies are in place for individual residents to include strategies for minimising the risk of future falls. Corrective actions around falls prevention are implemented. Pressure injury preventions are also discussed with staff and training has been provided around pressure injury prevention. There are resident/relative surveys conducted and analysed. The February 2018 resident/relative

		survey has been conducted. Each section of the survey has been analysed and compared to the previous year, with a follow-up letter sent to all relatives and residents with improvements to be made to the service as a result.
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	The accident/incident process includes documentation and analysis of the incident and also separation of resident and staff incidents and accidents. Ten incidents occurring in November 2018 were reviewed. Incident forms record if family has been contacted. Each event involving a resident includes a clinical assessment and follow-up by a registered nurse. Neurological observations were consistently documented for unwitnessed falls as per policy. Accidents and incidents are analysed monthly with results discussed at the combined quality/staff meetings. The management team are aware of situations that require statutory reporting. There have been no pressure injuries or outbreaks since the previous audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Six staff files sampled (the registered nurse, the activities coordinator a cleaner and three caregivers) showed appropriate employment practices and documentation. Current annual practising certificates are kept on file. The orientation package provides information and skills around working with residents with rest home level care needs and were completed in all staff files sampled. There is an annual training plan in place and implemented. Staff training is provided at least monthly and all core subjects have been covered in the programme in the past two years. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. As part of this process, management ask a selection of residents including YDP residents what their thoughts are of each staff member, and these comments are included at the bottom of the appraisal document. Residents stated that staff are knowledgeable and skilled.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or	FA	There is a documented rationale for staffing the service. The manager (non-clinical) works full-time and is on-site Monday-Friday. A registered nurse works five days per week (Monday to Friday). A second RN position for 30 hours a week is currently being advertised to provide seven-day cover for the facility and share on call. After hours clinical support is provided by the registered nurse. Non-clinical matters are referred to the manager.

experienced service providers.		The facility is currently fully occupied with 33 rest home level residents. There are three caregivers on duty each morning (two long shifts and one short shift which is flexible in times of high acuity). There are two caregivers on duty on the afternoon (both long shifts) with a tea assistant who is a qualified caregiver available to help if required. Night shift is covered by two caregivers (8.5hr shift). Staff and residents interviewed confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored in the locked nurses' station, where they cannot be accessed by people not authorised to do so. Individual resident files demonstrated service integration. Entries are legible, dated and signed by the relevant staff member including designation.
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	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. An information booklet is provided for families and residents prior to admission. Admission agreements reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. The service uses the yellow envelope system for all hospital transfers. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs and senior caregivers who administer medications complete annual medication competencies. Annual in-service education on medication is provided by the registered nurse and one chart representatives. All care staff medications (blister packs) are checked on delivery against the medication chart and any discrepancies fed back to the pharmacy. All

complies with current legislative requirements and safe practice guidelines.		medications are stored safely in a locked trolley or locked cupboard within the secure nurses' station. Standing orders are not used. One self-medicating resident had a self-medication competency completed and reviewed three monthly by the GP. The medication fridge is monitored daily. All eye drops were dated on opening. Twelve electronic medication charts were reviewed. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three monthly. The administration signing sheets reviewed identified medications had been administered as prescribed. Prescribed 'as required' medications include the indication for use. The dose and time given is signed for on the administration signing sheet. Pain monitoring forms record the effectiveness of pain relief.
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	All meals and home baking are prepared and cooked on site by experienced cooks. A registered food control plan is implemented and due for review January 31, 2019. There is a five-weekly seasonal menu in place which had been reviewed by a dietitian in May 2017. The cook is informed of resident dietary needs and changes. Likes and dislikes are accommodated. Additional or modified foods such as soft foods, pureed and vegetarian meals are provided. Residents are surveyed annually and confirmed resident satisfaction with meals. Residents and family members interviewed were very complimentary about the meals provided. The kitchen is located centrally and is adjacent to the dining room. All meals and baking are prepared on-site. Meals are plated, and caregivers deliver to residents in the dining room. Fridge and freezer temperatures are monitored and recorded daily. End-cooked temperatures are taken twice daily. All containers of food stored in the pantry are labelled and dated. All perishable goods are date-labelled. A cleaning schedule is maintained.
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	There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whānau as appropriate if entry was declined.
Standard 1.3.4: Assessment	FA	The RNs complete an initial assessment on admission including risk assessment tools as appropriate. An interRAI assessment is undertaken within 21 days of admission and six monthly, or

Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.		earlier due to health changes for long-term residents under the ARCC. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the long-term care plan. The long-term care plans reflect the outcome of the assessments.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Residents' long-term care plans reviewed were resident-focused and individualised. Care plans documented the required supports/needs to reflect the resident's current health status. Relatives and residents interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans. Caregivers complete an interRAI questionnaire prior to interRAI assessment and care plan reviews. Care plans are reviewed six monthly and updated to reflect changes to supports/needs. Support planning for YPD residents includes community participation and input into their care planning. Short-term care plans were sighted for short-term needs and these were either resolved or transferred to the long-term care plan. There was evidence of allied health care professionals involved in the care of the resident.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the contact with family member record page held within the resident file. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. On the day of audit there were no current wounds. Previous wound assessments and wound care plans were reviewed and evidenced dressing types and evaluations on change of dressings. The RN reported there is access to a wound nurse specialist and district nurses for advice for wound management. Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used. Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food and fluid intake and challenging behaviours.

Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	CI	A qualified, experienced and enthusiastic diversional therapist (DT) typically works a minimum of 30 hours per week Monday to Friday. Hours are flexible to enable attendance at special events at weekends and evenings and individual needs according to resident interests. Volunteers and caregivers assist with individual and group activities during the week and on weekends. Two long-serving volunteers are available as required and provide focused support to specific residents. The activity programme is varied and meets the recreational needs of the resident group. The activity coordinator attends on-site in-service and is in regular contact with other diversional therapy group meetings. Activities are meaningful and include (but are not limited to); van outings, movie afternoons, exercises, entertainment, craft, painting and art, games, and activities with other facilities. There are visiting churches, library, grammar school students and pet therapy. On the day of audit, residents were observed participating in a variety of activities. One-on-one activities are provided for residents who are unable or choose not to be involved in group activities. There was evidence of one resident who initially did not participate in activities who now actively participates in all exercise programmes in preparation for the next cruise adventure. Younger persons are supported to maintain their community links and are also involved in meaningful activities such as assisting with the activities or tasks within the villas and grounds. Personal planning/assistance is allocated within the activities programme for all residents and also focuses on the needs of younger people in regard to shopping, individualised activities and interests. A resident activity interest form is completed on admission. Each resident has an individual activity plan which is reviewed six monthly. The service receives feedback on activities through one-on-one feedback, surveys of individual activities, outings and entertainment, resident's meetings and annual resident and relative surveys. The service has exceeded the standard related to provision of an activities programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated six monthly for four of the six resident files reviewed. Two residents had not been at the service six months. Written evaluations identified progress towards goals. The GP reviews the residents at least three monthly or earlier if required. Short-term care plans reviewed had been evaluated at regular intervals. Ongoing nursing evaluations occur as indicated and are documented on care plans and within the progress notes.
Standard 1.3.9: Referral To Other	FA	Referral to other health and disability services is evident in the residents' files sampled. The service

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.		facilitates access to other medical and non-medical services. Referral documentation is maintained on residents' files. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies and procedures in place for waste management. Residents, staff and visitors are protected from harm through safe practice. There is an approved system in place for the safe disposal of sharps. Chemicals are labelled with manufacturer labels. There are designated areas for storage of chemicals and chemicals are stored securely. Laundry and sluice rooms are locked when not in use. Product use information is available. Protective equipment including gloves, aprons, and goggles are available for use by staff. Staff interviewed were familiar with accepted waste management principles and practices.
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 has 33 rooms over two levels. There are five rooms upstairs with communal shower and toilet facilities and a small lounge. Access upstairs is by two flights of stairs. One stairwell has an electronic stair chair lift, which had its last annual service in June 2018. There is a current building warrant of fitness that expires 20 December 2018. There is a maintenance person employed for 15 to 30 hours per week and on-call for urgent facility concerns. A reactive and planned maintenance schedule is in place There has been ongoing refurbishment including the front entrance, new carpets and ongoing enhancement of outdoor areas. Annual calibration, functional checks and electrical testing and tagging of equipment is completed by external contractors annually. There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the well maintained and landscaped outdoor areas. Seating and shade is provided. The facility has a designated resident smoking area for residents in an external undercover area. The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs and pressure injury resources to safely deliver the cares as outlined in the residents' care plans.

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	A number of resident's rooms have either full or shared ensuites while some have toilets only. There are communal toilets and showers for those in rooms without ensuites. Communal shower/toilets have privacy locks. Residents confirmed that staff respect their privacy while attending to their hygiene cares.
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 rooms are single. Each resident room has individual furnishings and décor. There is adequate room for residents to safely manoeuvre using mobility aids. Residents and families are encouraged to personalise their rooms as viewed on the day of audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas within the facility include a large dining area and lounge adjacent to the central kitchen and smaller lounges and seating areas. There are a number of small private areas available for residents including younger persons. Activities take place in any of the communal areas. All furniture is safe and suitable for the residents. Communal areas are easily accessible to residents.
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	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. All linen and personal clothing is laundered on-site. Caregivers complete laundry duties. There is a designated laundry with a defined clean/dirty area. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings and surveys. There are dedicated cleaners Monday to Sunday to carry out cleaning duties. Cleaning trolleys are stored safely when not in use. Residents and relatives interviewed were satisfied with the laundry service and cleanliness of the communal areas and their bedrooms.
Standard 1.4.7: Essential,	FA	Emergency management plans are in place to ensure health, civil defence and other emergencies are covered. Fire and evacuation training has been provided. Fire drills are conducted six monthly.

Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.		The last fire evacuation drill occurred on 6 June 2018. A civil defence kit is stocked and checked monthly. Alternative heating and cooking facilities are available. Emergency lighting is installed. A generator is available when needed. Extra blankets, torches and supplies are available. There is sufficient food in the kitchen to last for three days in an emergency. There are sufficient emergency supplies of stored water available on-site. Appropriate training, information, and equipment for responding to emergencies is part of the orientation of new staff. There is an emergency management manual in place. External providers conduct system checks on alarms, sprinklers, and extinguishers. An evacuation list identifies the requirements of individual residents. First aid supplies are available. There is a staff member on duty across 24/7 with a current first aid certificate. Call bells were appropriately situated in all communal areas and in each bedroom and ensuite.
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	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The facility is heated by a mix of underfloor electric heating, wall panels and heat pumps (all of which are electric). Residents and family interviewed stated the environment is comfortable.
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	Glendale Retirement Home has an established infection control (IC) programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the designated infection control officer (ICO) with support from all staff. Infection control matters are routinely discussed at all quality/staff meetings. The infection control programme has been reviewed annually. Responsibility for infection control is described in the ICO job description. The ICO has attended relevant external training on infection control and prevention. Annual infection control education has been provided for the staff. The infection control coordinators oversee infection control for the service and are responsible for the collation of infection events. The infection control programme has been reviewed annually. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents and staff are offered the influenza vaccine. There have been no outbreaks.

Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme. The ICO is responsible for infection prevention and control. The infection control team is all staff through the quality/staff meeting. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. The infection control officer has access to infection control expertise within the DHB, wound nurse specialist, public health, laboratory and GP. The GP monitors the use of antibiotics.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies and procedures manuals have been developed by an external aged care consultant and are reviewed annually. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been developed by an aged care consultant and reviewed annually in consultation with the infection control coordinator for southern laboratories. The policies were last reviewed in May 2018. An outbreak kit is readily available, and contents checked monthly.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The staff orientation programme includes infection control education. The ICO has completed infection control updates and provides staff in-service education which has occurred in 2018. Education is provided to residents in the course of daily support with all residents interviewed able to describe infection prevention practice that is safe and suitable for the setting. The infection control officer is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Staff complete hand hygiene competencies and assess each other on their techniques. Resident education is expected to occur as part of providing daily cares.
Standard 3.5: Surveillance	FA	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Systems in place are

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		appropriate to the size and complexity of the facility. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and analysed monthly to identify areas for improvement or corrective action requirements. Outcomes and actions are discussed at quality/staff meetings and results posted for staff to view. Benchmarking occurs against industry standards. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager or registered nurse. There have been no outbreaks since the previous audit. The GP reviews antibiotic use at least three monthly with the medication review.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint or enablers. The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence. Staff have been trained in the management of behaviours that challenge, restraint and enablers. All staff must read monthly policies in the communication folder around restraint. A restrain/enabler register is maintained.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	CI	The service has conducted a number of quality improvement projects where a review process has occurred, including analysis and reporting of findings has occurred. There is evidence of action taken based on findings that has made improvements to service provision. The projects	The service identified an increase in the number of falls in the early evening - (32 falls were recorded for June; 19 for July and 24 in August). A meeting was held with the manager, RN and diversional therapist (DT). A trial was commenced on separating out the staff breaks, ensuring residents are reminded and assisted with toileting and brought back to the lounge or dining room areas if they want to. The DT has organised for board games, music, colouring books, craft materials and the like to be available for residents to use in the evenings. All residents were encouraged to go to the dining room for meals, the DT organised some daily exercises to help increase stamina and mobility in the hope of decreasing falls. There are posters dotted around the corridors beside handrails, so residents can stop and practice their exercises. Staff have engaged in this and actively encourage residents to participate in their exercise programme. Progress is discussed at staff meetings. Nine days into the trial staff contacted the manager to express their observations in the marked reduction in the number of falls, and the increase of residents attending the dining rooms, and the enjoyment of increased conversations at the dining tables. Twenty days into the trial there were a total of five falls recorded. A map of the building was placed in the staff meeting folder and each time a resident had a fall, the area was marked with a dot to identify high risk areas. September and October falls rates were 10 and 11 respectively. Staff and management believe the changes

		include reviewing if the improvements have had positive impacts on resident safety.	that have been made have not only decreased the number of falls but have also helped certain residents sleep better at night. Previously some residents who did not stay up for supper, are now enjoying activities in the evenings until after suppertime. Management reported there has been a positive increase in staff morale and the change has been received in a positive manner. It was decided in November to cease the trial and make the changes permanent
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.	CI	The monthly activities programme is developed in conjunction with residents at monthly meetings. Each month the residents forward suggestions for day trips, special activities and large outings and holidays. All options are considered, and plans put into place to achieve goals	The annual activities programme is planned in conjunction with residents. Objectives of the activities programme are to ensure residents can continue to be involved in worthwhile activities within the community and contribute with planning and preparation for special events. Larger events are discussed with management and plans implemented to achieve the resident's goals. A number of successful and memorable events have occurred this year. In early 2018, residents enjoyed going to Timaru and watching the cruise ships come and go. On one of these outings the residents raised how much they would like to go on a cruise. With the support of management, and input from residents, families and staff, the diversional therapist arranged an eight-night cruise to Fiji for four residents with one-on-one staff support. This event was very successful and a further cruise for seven residents is in the planning stage. Other special events have included (but are not limited to) a four-day holiday to Hawea for seven residents, a gardening initiative actively involving residents in purchasing, planning and planting the gardens, involvement in routine community tasks such as collecting the mail, setting the tables and clearing tables and folding washing. The success of this approach is reflected both at an individual and service level. Residents interviewed reported a sense of worth, achievement and purpose. In preparation for the next cruise, one resident is actively increasing his fitness level by attending daily exercise classes, others are applying for passports for the first time. After each activity, surveys are distributed to residents asking for both positive and negative feedback and options for improvement. The diversional therapist summarises the results in a review form and the information is discussed with management, and changes made. A yearly satisfaction survey has shown an increasing satisfaction each year over the last three years. Very good results have improved from 67% in 2016 to 78% in 2017 and 84% in 2018. In 2018 100% of results were either good or very good.

End of the report.