

Masonic Care Limited - Glenwood Masonic Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Masonic Care Limited
Premises audited:	Glenwood Masonic Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 October 2020 End date: 29 October 2020
Proposed changes to current services (if any):	As requested by HealthCERT, a reconfiguring has been included in this report. Reconfigure a double room in unit 1 into a single room with an ensuite and build a new room with ensuite onto the existing building. In unit 2 build a new single room at the end of the passageway joining onto the existing passageway and new double suite with an ensuite created from an existing office.

Total beds occupied across all premises included in the audit on the first day of the audit: 43

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

Glenwood Masonic Hospital provides residential care for up to 48 residents who require rest home and hospital level care. The facility is operated by Masonic Care Limited.

This surveillance audit was conducted against the Health and Disability Service Standards. The audit process included review of policies and procedures, review of residents' and staff files, observations, and interviews with residents, family/whānau, management, staff and a general practitioner.

Reconfiguration includes creating bedrooms and ensuites built from new and existing rooms.

A continuous improvement rating continues to be awarded relating to planned activities provided seven days a week.

Areas requiring improvement at the previous audit relating to residents' care plans not fully describing required support, ongoing medication training and monitoring of cleaning and laundry processes have been addressed.

There are no areas requiring improvement from this audit.

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.

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

A complaints register is maintained with complaints resolved promptly and effectively. There have been no complaint investigations by an external agency since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

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

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

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated, analysed and evidenced corrective action plans are developed and

implemented. Quality meetings include infection control, restraint and health and safety. Various staff meetings are all held on a regular basis.

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents of Glenwood Masonic Hospital have their needs assessed by the multidisciplinary team on admission and within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is run by three diversional therapists. The programme provides residents with a variety of individual and group activities seven days a week and enable residents to maintain links with the community. A facility van is available for outings.

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

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

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using enablers and restraints at the time of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Surveillance of aged care specific infections is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	19	0	0	0	0	0
Criteria	1	45	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints policy, flow chart and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there are complaints information and forms available throughout the facility.</p> <p>The complaints register shows five complaints have been received in the past 12 months. The facility manager (FM) is responsible for the management of complaints. Documentation was reviewed for two complaints and evidenced Right 10 of the Code has been met. Staff interviewed demonstrated a good understanding of the complaint process and what actions are required.</p> <p>The FM reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p>
Standard 1.1.9: Communication Service providers communicate effectively with	FA	<p>Residents and families interviewed stated they were kept well informed about any changes to their/their relative's status and outcomes of regular and any urgent medical reviews. This was supported in the residents' files reviewed. Staff understood the principles of open disclosure, which is supported by policy and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Interpreter services can be accessed when required. There were no residents requiring an interpreter at the time of</p>

consumers and provide an environment conducive to effective communication.		audit.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Masonic Care Limited is governed by a board of trustees which meets 11 times a year. A strategic business plan 2016-2021 includes a purpose, vision, mission, goals and operational development. The facility has specific business goals that are reviewed throughout the year to monitor progress and then formally annually. Two weekly zoom meetings are held with the chief executive officer (CEO) and other facility managers within the group when a wide ranges of activities are reported on. The FM reported the FM and chief executive officer (CEO) discuss activities relating to Glenwood Masonic Hospital via phone at least weekly. Quarterly meetings are held with the CEO and managers where the overall activities concerning the facility are reported on and discussed. Facility monthly management meetings are held with the senior team and chaired by the FM. Interview with the manager and review of meeting minutes confirmed this.</p> <p>The FM reported zoom meetings were held weekly with the DHB during the Covid 19 lockdown and are fortnightly now. The FM reported these have been and are informative and keep everyone up to date.</p> <p>The service philosophy and mission statement are in an understandable form and are available to residents and their family / representative and other services involved in referring people to the service.</p> <p>The facility manager has extensive experience in the aged care sector, is a RN and was appointed to the position in June 2015. The FM is supported by a clinical nurse leader (CNL) who is a registered nurse and was appointed to their current position in October 2016. The CNL is responsible for oversight of clinical care. The FM and CNL are supported by head office staff. Interviews with the FM and CNL and review of their files evidenced they have undertaken on-going education in relevant areas.</p> <p>Five of the eight RNs, plus the FM and CNL are interRAI trained and have current competencies.</p> <p>Glenwood Masonic Hospital is certified to provide hospital and rest home level care. On the day of audit there were 21 hospital level care residents including one resident under the age of 65 years under the Long Term Support – Chronic Health Conditions’ contract with the DHB and one YPD resident under the age of 65 years under a contract with the Ministry of Health. There were 22 rest home level care residents including six residents under an ‘Occupational Right Agreement’ (ORA) and one resident under the respite contract.</p> <p>The service has contracts with the DHB to provide Aged Related Residential Care, Health Recovery Programme, Long Term Support – Chronic Health Conditions’ ‘Residential Care for Palliative Care Patients’ and ‘Respite Services’.</p> <p>A letter to the provider from HealthCERT dated the 28 February 2020 saying a partial provisional audit was to be completed relating to the reconfiguration was sighted. The FM reported they queried this as the reconfiguration is in</p>

		<p>two stages. Several emails were sighted from the DAA Group, HealthCERT and the DHB relating to this. Including that the DHB had visited the facility and supports the reconfiguration. HealthCERTs email of the 24 June 2020 states that as the DHB has no concerns therefore HealthCERT is happy for the beds to be occupied and follow up with an unannounced surveillance audit.</p> <p>Reconfiguration consists of a double room in unit 1 changed to a single room with an ensuite and the build of a room with ensuite onto the existing building. In unit 2 the build of a single room at the end of the passageway joining onto the existing passageway and double suite with an ensuite created from an existing office.</p> <p>The reconfiguration does not increase the certified number because the exiting double rooms have always been used for single accommodation.</p> <p>All bedrooms have been approved as dual purpose.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Quality and risk management plans guide the quality programme. Purpose, goals and objectives and scope are included in the plans.</p> <p>The resident satisfaction survey completed in 2019 evidenced high satisfaction with the services provided including those residents under the age of 65 years.</p> <p>Completed audits for 2020, clinical indicators and quality improvement data were recorded on various registers and forms. Review of the quality improvement data provided evidence the data was being collected, collated, and analysed to identify trends and corrective actions are being developed, implemented and evaluated. Quality data is benchmarked including graphs, by an external agency and within the group.</p> <p>Monthly quality (including infection control, health and safety and restraint and risk management), staff and RN/EN meetings are held monthly and minutes were reviewed. The FM and quality coordinator stated quality data is discussed at the various meetings. There was documented evidence of reporting on various clinical indicators and quality and risk issues in these meetings. Staff reported that copies of meeting minutes and comprehensive graphs are available for them to review in the handover room. This was confirmed by observations during the audit.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures that are Trust wide are reviewed at head office. Facility wide policies and procedures are reviewed two yearly, discussed at the quality meetings and staff are advised. All policies were current with a footer including the review date. Policies are held electronically for all staff to access and a hardcopy is kept in the handover room. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery.</p> <p>A health and safety manual is available. Risks are identified that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual and clinical risk. All areas have</p>

		a copy for the hazard/risk register specific to the area.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Review of the forms is completed by the RN and forwarded to the CNL who is responsible for any investigation, action plans and identification of any trends.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change to the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>The FM stated they are aware of essential notification reporting to external agencies. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM reported there have been four section 31s to HealthCERT since the previous audit relating to two residents absconding with police involvement and two pressure injuries.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are policies and procedures on human resources management. The skills and knowledge required for each position was documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed along with employment agreements, confidentiality statements, professional boundaries guidelines, police vetting and reference checks. Individual records of education were maintained for each staff member and were reviewed.</p> <p>An orientation/induction programme is in place and all new staff are required to complete this within three months of employment. Staff performance is reviewed at the end of the orientation, goals are set and a performance appraisal is completed annually thereafter. Orientation for staff covers the essential components of the services provided and staff are required to complete questionnaires. Staff confirmed they have completed an orientation and confirmed their attendance at on-going in-service education and that their performance appraisals are current.</p> <p>The education programme for 2020 evidenced education is provided via online and on site. The FM is responsible for the programme. External training is also attended. The local DHB provides opportunities for RNs to attend on-going education. Staff responsible for medication management have current medication competencies and ongoing training has been provided. The finding from the previous audit is closed. Restraint competencies are current.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme. Twelve HCAs have attended level four with one completing it. Eight have attended level three with two completing it</p>

		<p>and one has attended level two with five completing it.</p> <p>Annual practising certificates for all health professionals who require them were current. Staff files held current performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A documented rationale for determining staffing levels and skill mix is in place to provide safe service delivery. The policy includes skill mix, acuity and what triggers an increase in staffing or any decrease. The FM uses an electronic acuity/rostering tool and reviews rostering daily. Rosters were reviewed and showed staffing levels are adjusted to meet the changing needs of residents, acuity levels of residents on admission and the environment. Registered nurse cover is provided seven days a week over the 24-hour period. The FM and CNL are rostered on call after hours. Of the eight RNs employed, one is new to aged care. All the rest have one to nine years of experience and the FM 30 years of experience. The FM and CNL work full time Monday to Friday. There is one RN and six HCAs on the morning shift: one RN and five HCAs on the afternoon shift and 1 RN and two HCAs on the night shift. There is at least one staff member per shift with a current first aid certificate. Cleaning and laundry staff are dedicated to the roles and cover seven days a week. Two diversional therapists are employed to implement the activities programme seven days a week. There is a casual pool of staff including RNs.</p> <p>Care staff reported there is good staff cover available and they were able to complete the work allocated to them. They reported if someone is unable to work the team helps each other. The managers stated any shortfall can usually be filled using the casual pool or staff are offered extra hours. Residents and family members reported there were appropriate numbers of staff on duty to provide them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided. The ORA suites are included in the facility footprint and rostering includes these suites.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks</p>

		<p>and accurate entries.</p> <p>The records of temperatures reviewed for the medicine fridge and the medication room were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who self-administer medications at the time of audit.</p> <p>Medication errors are reported to the RN and CNL and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used, and instructions meet standing order guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in September 2018. Recommendations made at that time have been implemented.</p> <p>An up to date food control plan certificate verifies compliance by the Masterton District Council on 14 September 2020. The plans expiry date is 31 July 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. A previous continuous improvement around the presentation of moulied meals remains in place, however at the time of audit ongoing analysis of its effectiveness had not been ongoing. One family member when interviewed did however comment on how appealing to the eye the moulied meals were.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>All care plans reviewed reflected the support needs of residents, the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments of the residents are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. This finding addresses a previously required corrective action where it was found not all care plans reflected fully the required support the resident needed to achieve the desired outcomes. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations, and interviews verified the provision of care provided to residents of Glenwood Masonic Hospital (Glenwood) was consistent with their needs, goals, and the plan of care. The attention to meeting a range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. Families and residents reported requests for assistance are responded to promptly and staff are always willing and go out of their way to help. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by three diversional therapists seven days a week. A previous continuous improvement around the implementation of an activities programme seven days a week remains ongoing.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal three/six monthly care plan reviews.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included 'move and groove', a resident-initiated budgie breeding programme, visiting entertainers, quiz sessions and daily news updates. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN and the Clinical Nurse Lead (CNL).</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans are consistently reviewed for infections, pain, and weight loss. Progress is evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Wound management plans are evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is displayed at the main entrance that expires on the 27 July 2021.</p> <p>Structural alterations have been completed in unit 1 involving an existing double bedroom made into a single room with an ensuite and the build of a bedroom with ensuite onto the end of the existing building. These reconfigurations have been completed and the two rooms are occupied. Unit two alterations consist of a new single room built at the end of the passageway and a double suite with an ensuite for couples created out of an existing office. This reconfiguration is currently being built and mirrors unit1. Both reconfigurations mean the passageways throughout the facility will all be connected. The new bedrooms are spacious and both the bedrooms and ensuites have appropriate equipment and are fit for purpose.</p> <p>A certificate of public use from the local authority was sighted for the alterations that expires on 1 March 2021.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is washed and dried on site. Residents and families reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There are dedicated cleaners on site seven days a week who have received appropriate training. Staff demonstrated good knowledge of cleaning and laundry processes. The cleaners have lockable cupboards to store chemicals. All chemicals were in appropriately labelled containers. Residents and family stated the facility is cleaned to a high standard. Observations during the audit confirmed this. Cleaning and laundry processes are monitored daily by the FM and review of cleaning and laundry audits evidenced cleaning and laundry processes are monitored for effectiveness. The audit programme includes audits for cleaning and laundry processes. The finding from the previous audit is closed.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The evacuation plan was approved by the New Zealand Fire Service on the 12 August 2010. A statement of completion for fire protection systems provided by the company registered by the local authority was sighted for the alterations. A new application was lodged in September 2020 with the NZ Fire Service. The NZ Fire Service has advised once the alterations to unit 2 have been completed an inspection will be undertaken with a view to approving the new plan.</p> <p>An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly with a copy sent to the New Zealand Fire Service. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted, and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQ's.</p> <p>There are call bells to alert staff. Call system audits are completed on a regular basis and residents and families reported staff responded promptly to call bells.</p> <p>The external doors are secured in the evenings. An after-hours bell is available for visitors to gain entry.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections at Glenwood is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The Infection control coordinator (ICC) and CNL 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 quality, RN and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>A recent Norovirus outbreak in May 2020, saw 21 residents and 10 staff develop symptoms over 11 days. Good documentation of the outbreak has been kept. It was reported to the Masterton District Health Board and Public Health. Public Health commended the facility, via correspondence, over their management and control of the outbreak.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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. Restraint approval is included in the quality meetings and support and oversight for enabler and restraint management is discussed. Staff interviewed demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit five residents were using restraints and three residents were using enablers. Enablers are the least restrictive and used voluntarily at the resident's request. The restraint coordinator, who is the CNL has a sound knowledge regarding restraint minimisation and safe practise. Equipment used to minimise restraint use include sensor mats, landing mats, high low beds and wedges.</p>
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Specific results for criterion where corrective actions are required

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

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	CI	A previous continuous improvement around extending the activities programme at Glenwood from five to seven days a week remains in place. When one of the diversional therapists left and the formalised seven day a week programme was unable to be offered, care staff were used to offer movies and games to residents over the weekend. The availability of care staff to do this was often compromised by the demands of the residents' daily care needs, and their lack of training in meeting residents recreational needs. Residents meeting minutes expressed dissatisfaction with the weekend programme no longer being available at the calibre previously offered. After a gap of six weeks, the programme was reintroduced with a diversional therapist employed to continue the programme at the weekend. Residents subsequent satisfaction with the programme has increased again.	The activities programme at Glenwood was expanded beyond the usual Monday to Friday activities programme to provide a formalised activity programme seven days a week. The programme was also extended to later in the afternoons to accommodate the needs of residents with dementia. This has resulted in an ongoing improvement in resident satisfaction with the activities programme.

End of the report.