

# Masonic Care Limited - Glenwood Masonic Hospital

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Masonic Care Limited
<b>Premises audited:</b>	Glenwood Masonic Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 10 November 2021      End date: 11 November 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	48

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Glenwood Masonic Hospital (Glenwood), in Masterton, is one of the facilities owned and operated by Masonic Care Limited. Glenwood have contracts to provide rest home and hospital level care, palliative care, non-aged residential care to younger people with physical and/or intellectual disabilities, a health recovery programme, short term residential care and longer term support for chronic health conditions for up to 48 residents. All beds are dual purpose.

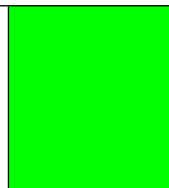
The service is managed by a facility manager supported by a management team consisting of a clinical nurse manager, administrator coordinator and quality coordinator. Since the last audit, a director of nursing has been employed by the Masonic Care Board and a clinical governance process has been commenced. A new clinical nurse manager has been employed at Glenwood. An electronic monthly reporting tool and an electronic resident care record has been introduced. There have been no facility changes since the last audit. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contracts with the district health board and the Ministry of Health. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a nurse practitioner.

The service is dedicated to providing the best care for their residents and continue to look at ways to improve services. No areas for improvement have been raised in 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.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents of Glenwood when they are admitted. Opportunities are provided to discuss the Code, consent, and availability of advocacy services at the time of admission and thereafter as required.

Services at Glenwood are provided in a manner that respects the choices, personal privacy, independence, individual needs, and dignity of residents. Staff were observed to be interacting with residents in a respectful manner.

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

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

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

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

There is a complaints process which meets the requirements of the legislation.

## 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.

The strategic plan included the vision, direction, four goals, values and mission statement of the organisation, with these driving the quality and risk management systems. The plan includes appropriate references to younger people with disabilities who are residents. Monthly reporting templates are used by the facility manager, which go to the chief executive and the director of nursing and allow for monitoring of the services provided. The chief executive and director of nursing provide reports to the governing body. An experienced and suitably qualified person manages the facility.

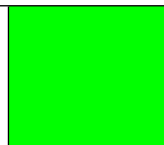
The quality and risk management system includes collection and analysis of quality improvement data, identifies trends, benchmarking, and leads to improvements where required. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented where applicable. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery to all residents and were current and reviewed regularly.

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

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

Access to the facility is appropriate and efficiently managed with liaison between Focus Wairarapa District Health Board (Focus) and the clinical team. Relevant information is provided to the potential resident and their family to facilitate admission to the facility.

The residents' needs are assessed by the multidisciplinary team on admission and within the required time frames. Care plans are individualised, based on a comprehensive range of information, and accommodate any new problems that might arise. The residents' files reviewed, evidenced that the care provided, and the needs of the residents are reviewed and evaluated on a regular and timely basis. Residents are referred to other health providers as required. Shift handovers and communication sheets promote continuity of care between the shifts in each area of the facility.

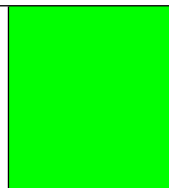
The planned activity programme is delivered seven days a week by two part time diversional therapists and supported by an activities assistant. The programme provides the residents with a variety of individual and group activities and maintains their links with the community. There is a facility van available for outings, as Covid-19 allows.

Medicines are managed according to the policies and procedures which are based on current best practice and consistently implemented. Medications are administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with any special requirements catered for. There are sandwiches and snacks available for rest home and hospital residents 24 hours a day. Policies guide the food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with the meals provided.

## 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.

The facility meets the individual needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical and biomedical equipment have been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible and safe and shade is provided in summer with seating available. There are multiple areas provided which are suitable for younger people with disabilities.

Waste and hazardous substance management was in place. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are now being safely stored. Personalised equipment for younger people with disabilities is well maintained and safely stored in their rooms. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. The service's emergency plan meets the special needs of younger people with disabilities in an emergency. Fire evacuation procedures are regularly practised. Security is maintained.

## Restraint minimisation and safe practice

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

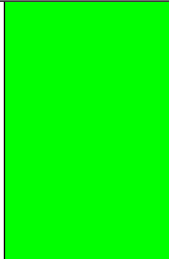


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests.

Seven residents had restraints in use during the audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs for all restraints. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed if required.

Staff demonstrated good knowledge around the principals and practice of infection control, guided by relevant policies and supported with regular education.

Age care specific infection surveillance is undertaken, with data analysed, benchmarked and results reported through to all levels of the organisation. Follow up action is taken as and when required.

Covid-19 related processes are in place to manage the changes in the response levels as appropriate to aged care and as per the Ministry of Health guidelines.



## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	50	0	0	0	0	0
<b>Criteria</b>	0	101	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

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

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the service are on display and available throughout the facility in both English and te reo Māori. Family members and residents spoken to were aware of the Advocacy Service, how to access this and their rights to have a support person. Staff are also aware of how to access the Advocacy Service if this is required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment. The facility encourages visits from family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with the staff. Visiting is currently restricted to afternoons and some outings due to the restrictions of Covid-19.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy meets the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Feedback forms are available at reception.</p> <p>The complaints register reviewed, with the facility manager (FM), showed five complaints were received in 2020 and six complaints have been received this year. All complaints were closed and a sample of three reviewed (received this year), showed that actions taken, through to an agreed resolution, were documented and completed within the timeframes of the Code. Action plans showed any required follow up and improvements have been made where possible. The FM is responsible for complaints management and follow up. They spoke of timely reporting serious issues to the director of nursing (DoN) and/or chief executive (CE) where appropriate. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>When interviewed, the residents and family/whanau of Glenwood reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussion with staff. The Code is displayed in English and te reo Māori throughout the facility. Information on how to make a complaint and provide feedback is available for residents and families.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and their families confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares, by ensuring resident information is held securely and privately, when exchanging verbal information and during discussion with families the general practitioner (GP) and nurse practitioner (NP). All residents have a private room. There are several lounges located throughout the facility providing quiet areas to chat away from the main communal areas.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and quite often the community activities comes to the facility, as Covid-19 allows. Each resident's care plan includes documentation related to the resident's abilities and strategies to maintain and maximise their independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs have been identified, documented, and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to be occurring during the orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is one resident at Glenwood whom, identifies as Māori. The family/whānau are involved in planning of care and identifying any specific cultural requirements. This is yet to be completed, as the resident has only recently been admitted.</p> <p>Staff receive annual education to enable them to support residents who identify as Māori to integrate their cultural values and beliefs. The principals of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau. There is a current Māori health plan and guidance on tikanga best practice is available. There are staff who identify as Māori in the facility and they can also act as a resource.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	<p>FA</p>	<p>Residents and their families verified that they were consulted on their individual culture, values and beliefs and that staff respected these. There are several staff who can act as interpreters if required. Access is also available to an external service. Residents' personal preferences required interventions and special needs were included in all care plans that were reviewed. For example,</p>

services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		likes and dislikes and attention to preferences around activities of daily living.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed, confirmed that residents were free from discrimination, harassment or exploitation and felt safe. The facility nurse practitioner (NP) also expressed satisfaction with the standard of services provided to the residents. The induction process for staff includes education related to professional boundaries and expected behaviour to support good practice. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service provides and encourages good practice through evidence-based policies, input from external specialist services and allied health professionals, for example wound care, palliative care, and online education for staff. The NP confirmed that the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported that they receive management support for external education and access their own professional networks. Ongoing yearly training is provided both in-house and online and from external providers.</p> <p>Examples of continuous quality improvement projects were sighted:</p> <ul style="list-style-type: none"> <li>- A Falls Prevention and Management project was initiated in July 2020 to address the rise in falls. RN staffing issues resulted in the project being placed on hold. A re-focus has been placed back on the project in an effort to reduce the number of falls in the facility.</li> <li>- The dining experience has been improved, where-by the dinning room tables were being set with table clothes and flowers from the garden.</li> <li>- The facility is currently implementing an electronic record system for patient care. This was commenced and not fully completed due to RN staffing issues and is to be resumed now that the recruitment of RNs has occurred.</li> </ul>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to	FA	Residents and family members stated they were kept well informed about any changes to their own or their relative's status, they are advised in a timely manner about any incidents or accidents and the outcomes of regular or urgent medical reviews. This was clearly documented in the residents' records that were reviewed and family communication sheets. There was also evidence of

<p>effective communication.</p>		<p>resident/family input into the care planning process and the multi-disciplinary meetings.</p> <p>Staff understood the principals of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access an interpreter should this be required. Several staff members are bi-lingual.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic business plan 2016 to 2021, is comprehensive and outlines the purpose, values, mission and four goals of the organisation. The chief executive (CE) stated the Board meet 11 times a year and were considering their next strategic plan. The facility has a specific business plan and incorporate the organisation wide strategic goals. Two weekly 'ZOOM' meetings are held with senior management and other facility mangers, as well as regular face to face meetings with the CE and director of nursing (DoN). Planning for younger people with disabilities is reflected in the personal family centred approach of the organisation.</p> <p>The organisation has implemented a monthly electronic reporting tool (Quality Performance System (QPS)), which collects data on business management, clinical indicators and quality data. This allows benchmarking with other Masonic and overseas facilities. A sample of these monthly reports by the facility manager (FM) to the CE and DoN showed adequate information to monitor performance is reported including financial performance, trending and emerging risks and issues. The CE and DoN report to the Board monthly. Review of the Masonic Village Limited Board pack for November 2021, showed evidence that the Board is well informed of the facility's risks and emerging issues.</p> <p>The service is managed by a FM, who is a registered nurse with post graduate qualifications related to health and business management. They have held senior positions within the aged care sector for over 30 years and have been in their present role for seven years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CE and FM spoke of the budget within which the FM manages, which includes capital expenditure. There is a process for looking at replacement of capital items. The FM confirmed knowledge of the sector, regulatory and reporting requirements and maintain currency through attending meetings and receiving updates from various organisations. They attend the two monthly provider meetings with the DHB. The CE is on the executive of the New Zealand Aged Care Association and ensures the facilities are aware of national issues and movements within these.</p> <p>The service holds contracts with the DHB for rest home and hospital level care, a health recovery programme, short term residential care and longer term support for chronic health conditions and residential palliative care. They have a contract with the Ministry for one resident under the younger</p>

		<p>person with a non-aged residential care with physical/intellectual disability (YPD) contract. The 48 residents were receiving services under these contracts:</p> <ul style="list-style-type: none"> <li>• 25 hospital level care, one being the resident under the YPD Ministry contract</li> <li>• 23 rest home level care, seven of whom are in the care suites with occupational right agreements.</li> </ul>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the facility manager is absent, the clinical nurse manager (CNM) will carry out delegated duties. The CNM commenced her role in June 2021 and is new to New Zealand and the aged care sector. The CNM is being supported by the FM, DoN and the NP, into this role. When the CNM is on leave there is a senior RN who has been with the organisation for a number of years who will take on the role. Staff reported they feel supported by the FM, CNM and RNs.</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>There is a quality management framework, which includes the dimensions of quality improvement and quality assurance. There is a quality improvement register and projects for continuous quality improvement are being undertaken (refer Standard 1.1.8). The 'QPS' benchmarking report is completed monthly and contains data related to complaints, adverse events, clinical indicators (falls, pressure injuries, medication errors, skin tears and infections) as well as patient and relative surveys data. This data is analysed, with benchmarking and trended occurring. This was confirmed in the Director of Nursing Quality and Risk Report October 2021. Also sighted was the last quarter Glenwood specific data analysis report which showed the trending by month over the last year.</p> <p>The CE spoke of the organisational risk register and the FM provided a copy of the Glenwood risk register which showed risks being identified, rated, mitigation strategies in place and residual risks. There is a separate health and safety risk (hazard) register, which is maintained by the administration coordinator who is the health and safety officer. The FM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements This showed hazards being identified and mitigated appropriately.</p> <p>Glenwood has an audit calendar, managed by the quality coordinator, which showed 18 annual audits (examples included; laundry and cleaning, medication staff responsibilities, residents surveys, meal delivery, health and safety) and 11 six monthly audits (examples included; hand washing, medication staff responsibility, clinical records, health and safety hazard identification and evacuation) occurring. Samples of these audits reviewed showed good completion of the tasks required and when areas of non-compliance were identified these have been rectified. Staff spoke</p>

		<p>of being part of these audits and receiving feedback on the audits when completed. Some audits were not able to be completed this year due to Covid-19 restrictions and a shortage of RNs in July.</p> <p>Glenwood has a range of meetings occurring regularly, these include:</p> <ul style="list-style-type: none"> <li>• Monthly residents' meetings</li> <li>• Quality, Health and Safety, Infection Control and Restraint Meetings, monthly</li> <li>• Management meetings - minutes sighted</li> <li>• RN/EN medication competent health care assistant monthly meetings</li> <li>• Staff meetings - monthly</li> </ul> <p>Review of the minutes of these meetings showed staff were informed of quality and risk data and issues being discussed.</p> <p>Resident and family satisfaction surveys are completed annually, this includes the family of the younger person being asked to be involved. The November 2020 surveys were reviewed:</p> <ul style="list-style-type: none"> <li>• The relative survey had 14 returned out of 40 surveys sent out</li> <li>• The residents survey, where a volunteer assisted residents to complete the survey, had 13 responses out of 32 residents</li> </ul> <p>The overall results, of these surveys, showed a high degree of satisfaction with the services being provided, with the majority of questions rated over 90 percent. Some areas scored lower than 80 percent, such as the food by relatives (76.9 percent) and residents (75 percent), answering of call bells by relatives (76 percent). (Refer criterion 1.2.8.1). Food is also discussed at the residents meetings and issues raised with the cook.</p> <p>There are Masonic Trust policies and Glenwood facility specific policies in place, all but a few were seen as being current. The FM stated there is work underway to see if there can be organisational wide policies which meet the needs of all facilities. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process with relevant NASC requirements for younger people. Policies are based on best practice. There is a document control system and footer to ensure a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p>
Standard 1.2.4: Adverse Event	FA	Glenwood has moved to the reporting of adverse events and near miss events electronically this year as part of the electronic record process. Staff reported no issue with this system. A sample of



<p>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>		<p>four incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported by the FM via the electronic reporting system to the DoN and CE. Analysis includes identification of individuals with multiple falls, time of fall and other parameters. Analysis of falls over a few months identified the events occurring in the afternoon and the organisation agreed to the increase in afternoon staff hours.</p> <p>The FM described essential notification reporting requirements, including for pressure injuries. In July, the lack of RNs was reported to the Ministry of Health.</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>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process included interviews, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of ten staff records (three healthcare assistants, the clinical nurse manager, administration coordinator, two registered nurses, a cook, a support staff member and diversional therapist) reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>There is a comprehensive staff orientation which includes use of a workbook with all necessary components relevant to the role and a support person. Staff who had recently been employed reported that the orientation process prepared them well for their role; this included the new clinical nurse manager. Staff records reviewed showed documentation of completed orientation and an annual performance review being completed.</p> <p>There is an annual calendar of continuing education, including the identified annual compulsory core skills training requirements. The CNM keeps a list of the annual medication competencies which includes the RNs, clinical nurse manager, enrolled nurses and health care assistants (HCAs), plus there are some HCAs who are trained as 'second checkers'. Glenwood have recently moved to online training which has improved uptake which has been hampered by Covid-19 and staffing issues. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB, with an external assessor being used for the programme.</p> <p>There are four of the seven RNs who are trained and competent to undertake interRAI assessments, plus the CNM, with one further RN booked for training in November.</p> <p>Records reviewed demonstrated completion of annual 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>	<p>FA</p>	<p>There are a number of documents which cover staffing, including the Masonic Village Trust staffing policy and two Glenwood hospital policies. These outline the processes used for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The FM uses, a well-established tool, determine staffing levels to meet the changing needs of residents.</p> <p>There is a set roster, managed by the quality coordinator, completed and circulated to staff one month in advance, with agreed annual leave identified and managed. There is a pool of casual HCAs to assist with unforeseen changes to rosters and HCAs also inform the quality coordinator if they are available for extra work. Review of a number of weekly rosters confirmed the staffing met the set pattern of the roster. However, there has been a pattern of sick leave and changes of duties emerging and HCAs reported it is consistently hard to manage the work allocated to them on morning duty, and at times they feel unsafe. This is disputed by the senior staff and current rosters show the numbers of staff meeting requirements.</p> <p>There has been a turnover of RNs and in July/August the roster was depleted of RNs to cover the duties which saw the FM, DON and CNM working to ensure coverage. RNs from other facilities were also used to assist and ensure safety. The Ministry was notified of this issue. New RNs are being orientated.</p> <p>All RNs and diversional therapy staff have a current first aid certificate and there is 24 hour a day, seven day a week (24/7) RN coverage in the hospital. Afterhours the CNM is on call. Residents and family interviewed were happy with the care provided. There were no comment expressing concerns about the level of staffing.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records are legible with the name and designation of the person stamped beside the entry.</p> <p>Archived records are held securely on site and are readily retrievable. They are then transferred to an offsite storage unit and kept for the required length of time before being destroyed.</p> <p>No personal or private resident information was on display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p>	<p>FA</p>	<p>Residents are admitted to Glenwood following assessment from the NASC (Focus), as requiring the</p>

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>level of care that Glenwood provides. Prospective residents and their families are encouraged to visit the facility prior to admission and are provided with written information about the service. All residents prior to admission have a Covid-19 screen and the facility are guided by MOH guidelines.</p> <p>Family members interviewed stated that they were happy with the admission process and the information that had been provided to them. Files reviewed contained the completed demographic information, assessments, and signed admission agreements in accordance with the contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the Wairarapa DHB 'Yellow envelope' system to facilitate the transfer of residents to and from acute care settings. There is open communication between all services, the residents, and the family. At the time of transition between services, appropriate information, including medication records and the care plan, is provided for ongoing management of the resident. All referrals are documented in the progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The Medication Management Policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. An RN and carer check the medications against the prescription, then sign and dates each pack into the electronic system. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries. Controlled drugs are signed in and a pharmacy check is carried out every six months and this was evidenced in the controlled drug register.</p> <p>The records of temperatures for the medicine fridge were reviewed and were within the recommended range. The medication room also had temperature checks taken at the time of the audit.</p> <p>Good prescribing practices were noted. These included the prescriber's signature and date recorded</p>

		<p>on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. There are standing orders in place and very occasionally verbal orders will be used until it can be charted electronically. Vaccines are not stored on site. The required Covid-19 vaccines have been given to both staff and residents except for those who did not want to be vaccinated. At the time of the audit there were no residents, self-administering medications, there is a policy and process in place should this occur.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 with a cook and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietician in September 2021 with all recommendations signed off.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Masterton District Council District Council. At time of audit, the kitchen was observed to be clean, and the cleaning schedule was maintained.</p> <p>Food temperatures, including for high-risk items, are monitored, and recorded as part of the plan using an electronic database.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. The kitchen provides a varied menu which supports residents with specific cultural food requirements. Special equipment to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and families/whānau interviews, satisfaction surveys and in residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau</p>	FA	<p>If a referral is received, but the resident does not meet the entry criteria, there are no vacancies, or the referral has been declined from the service due to inappropriate referral from Focus, there is a process in place to ensure that the prospective resident and family are supported to find an appropriate level of care.</p> <p>If the needs of the resident change and they are no longer suitable for the services offered a referral</p>

<p>is managed by the organisation, where appropriate.</p>		<p>for reassessment is made to Focus and a new placement is found in consultation with the resident and the whanau/family. This process was discussed with the facility manager (FM).</p> <p>There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>On admission, residents of Glenwood are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, cognition and behaviour, nutrition, and activities, to identify any deficits and to inform initial care planning. Within three weeks of admission, residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents' changing conditions require.</p> <p>Interviews, documentation, and observation verified the RNs are familiar with requirements for reassessment of a resident using the interRAI assessment tool when a resident has increasing or changing needs. All residents have current interRAI assessments completed by one of the trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans at Glenwood are paper based. They are in the process of changing over to an electronic patient management system. When reviewed, they reflected the support needs of the residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments were reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and family/whanau reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired</p>	<p>FA</p>	<p>Documentation, observations and interviews with residents and families verified that the care provided to the residents was consistent with their needs, goals and plan of care. The attention to meeting a diverse range of residents' needs was evident in all areas of service provision.</p> <p>The GP interviewed confirmed that medical orders are carried out in a timely manner and staff were very proactive at contacting the GP should a resident's condition change. Care staff confirmed that</p>

outcomes.		<p>care was provided as outlined in the documentation.</p> <p>A range of equipment and resources were available and suited to the levels 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 for the rest home and hospital is provided by two part-time diversional therapists and one part-time activities assistant 9.30 am – 5.00 pm seven days per week. The programme activities are developed to meet the needs of the residents and in accordance with Covid-19 restrictions. The activities assistant is currently completing their diversional therapist qualification supported by the diversional therapist.</p> <p>An activities assessment is completed on admission to ascertain the resident's needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate a plan that is meaningful to the resident. The activities programme is evaluated at the residents' meetings. This ascertains residents' likes and dislikes. There is regular documentation in each resident's progress notes all of which form part of the six-month multidisciplinary care plan review.</p> <p>Support is provided to support the Māori resident with activities culturally appropriate for them. It is the aim of the diversional therapists to get the residents engaging in the community as much as Covid-19 restrictions allow. There is a facility van available for drives on a weekly basis for both rest home and hospital residents.</p> <p>Activities reflected the residents' goals, ordinary patterns of life and included normal community activities, regular church services, knitting and visiting entertainers, pet therapy, and a walking group. Hospital and rest home residents have the same monthly activity programme. There are several lounge areas, as well as the individual's bedrooms where they can watch their own television or listen to the radio. The Activities Calendar is on display and each resident is given a copy of the monthly activities available for them to participate in. It emphasises and celebrates cultural beliefs on a regular basis.</p> <p>Residents and families can evaluate the programme through day-to-day discussions with the activities co-ordinator and by completing the six-monthly resident satisfaction survey and the six monthly multi-disciplinary team meeting. Residents and families interviewed confirmed the programme was interesting and varied.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans</p>	FA	<p>Residents' care is evaluated each shift and reported on in the progress notes. If any change is noted, it is reported to the RN.</p>

<p>are evaluated in a comprehensive and timely manner.</p>		<p>Formal care plan evaluations occur every six months in conjunction with the six monthly interRAI/clinical reassessment or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from that expected, the service responds by initiating changes to the plan of care.</p> <p>Short term care plans are consistently reviewed for infections, pain, weight loss, and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressings were changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has two main medical providers, residents may choose to use another medical practitioner. If the need for other non-urgent services is indicated or requested, the GP/NP sends a referral to seek specialist input. Copies of referrals were sighted in the residents' files, including to the wound care nurse. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as ringing an ambulance if the situation dictates.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There is a waste management policy and procedure which includes separation of waste, hazardous waste (clinical waste) and chemicals. Staff follow the documented processes. Waste is safely stored ready for removal by an external contracted company, cardboard is being recycled. Appropriate safe storage and signage is displayed for the liquid petroleum gas bottles.</p> <p>An external company is contracted to supply and manage laundry, cleaning and kitchen products and staff have received appropriate training for these as sighted in staff files and confirmed by staff interviewed. The chemical used in the dirty utility room was being stored under shelves in the room and not in the locked chemical storeroom. This was rectified during the audit. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. Spill kits were sighted in the dirty utility rooms.</p> <p>There is provision and availability of personnel protective equipment (PPE) (gloves, masks, face shields, gowns, nitrate gloves, goggles) and staff were observed using masks, aprons and gloves. There is a large store of PPE available to staff in the event of a move in the Ministry Covid-19 alert levels.</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>	<p>FA</p>	<p>A current building warrant of fitness (expiry date July 2022) was publicly displayed. Maintenance required for the warrant is being undertaken.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. The environment was hazard free and residents' safety was promoted. Personalised equipment is available for the younger residents with disabilities to meet all their mobility and equipment needs.</p> <p>There are multiple external areas that are safely maintained and were appropriate to the resident groups and setting. Younger people with disabilities can access all areas of the facility.</p> <p>Staff have access to maintenance books to report any issues identified. This showed a good response to issues raised. Staff confirmed they know these processes and confirmed a timely response. Residents and family members were very happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes ensembles, twelve shared facilities between two rooms, plus toilets available around the facility for residents and separate staff and visitor toilets.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment and accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Rooms are of a good size. Personal space is provided to allow residents and staff to move around, including with the use of equipment, such as hoists and walkers, within their bedrooms safely. All bedrooms provided are currently single accommodation. The FM spoke of some rooms that could be used for couples who wished to share a room. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There are storage areas to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>



<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are multiple communal areas available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs. There is one younger resident, who has their needs catered for, with specific activities.</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>Laundry is undertaken on site in a dedicated laundry. Support staff provide the service and demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents' clothing is managed inhouse and processes are in place to manage these. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. One residents' meeting minutes reviewed identified an issue with a lost item but this was resolved.</p> <p>There is a small designated cleaning team. These staff undertake appropriated training, and this was as confirmed in interview of cleaning staff and from training records. Trolleys used for cleaning were stored in a lockable cupboard and chemicals were in appropriately labelled containers. The dirty utility rooms were observed to need a clean and review of contents, which was undertaken during the audit.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</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>Policies, guidelines and flip charts for emergency planning, preparation and response were displayed and known to staff. This includes preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The service's emergency plan considers the special needs of younger people with disabilities. The current fire evacuation plan was approved by the New Zealand Fire and Emergency Service on the 17 December 2020. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on September 2021.</p> <p>Staff orientation includes fire and security training. RNs are all fire wardens and receive training for this as part of their orientation. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, 30,000 litre water storage tanks for washing, as well as bottled water for drinking, blankets, mobile phones and gas BBQ's were sighted and meet the National Emergency Management Agency recommendations for the region. There is an agreement with a local firm for a generator to be brought onto the site</p>

		<p>when required, as confirmed by the CE. There are torches available for emergency lighting.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported some issues with staff responding promptly to call bells (see CAR 1.2.8.1).</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and the RN on duty ensures these are secure at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some rooms and all care suites have doors opening on to outside patio areas. Heating is provided by large air conditioning units which provide heated radiators in residents' rooms in the communal areas. Some areas have wall mounted heat pumps. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Glenwood implements an infection prevention and control programme which is appropriate for the size and complexity of the service. A comprehensive and current infection control manual is available to staff and managers. There is evidence that formal reviews of the programme are completed annually.</p> <p>The registered nurse is the designated infection prevention and control co-ordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported through to management. Infection prevention and control matters are also discussed at registered nurse meetings, staff handovers, staff meetings and ultimately at management meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities and confirmed this had been further reinforced since the Covid-19 pandemic.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to</p>	FA	<p>The ICN has the appropriate skills, knowledge and qualifications for the role. Additional support and information can be accessed from the infection control team at the DHB, the community laboratory, the GP/NP and the public health unit, as required. The co-ordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p>

<p>implement the infection control programme and meet the needs of the organisation.</p>		<p>There is a Covid-19 management plan in place which details all the actions required by the service streams within the facility in response to each of the alert levels. The ICN and clinical manager confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standard and current accepted good practice. Policy review is ongoing and clearly documented on each policy the next review date. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are distributed around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and in ongoing education sessions. Education is provided by suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. At the time of the audit there had been no recent infection outbreaks.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, respiratory tract and skin infections. When an infection is identified, a record of this is documented in the resident's clinical record. The IPC coordinator reviews all reported infections, and these are documented. New infections and any required management plans are discussed at shift handovers, to ensure early intervention occurs.</p> <p>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 at meetings and during shift handovers. A good supply of personal protective equipment was available, and Glenwood has processes in place to manage the risks imposed by Covid-19.</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>There are new Masonic Trust policies and procedures and a Glenwood Hospital restraint minimisation policy both of which meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The CNL is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility. The CNL demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities, which are defined in the role description.</p> <p>On the day of audit, seven residents were using restraints. No residents were using enablers. Enablers, when used, are the least restrictive and residents consent to their use. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint use at the quality, health and safety, management meetings minutes, from files reviewed, and from interviews with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraints approved for use are documented in the policy documents. The restraint coordinator's job description outlines the role and responsibilities. Each restraint to be used is approved by the resident and/or whānau/EPOA, general practitioner or nurse practitioner and the restraint coordinator, using the Glenwood consent for use of restraint/enabler process.</p> <p>It was evident from review of the quality, health and safety, management group meeting minutes, review of two residents' files and interviews with the coordinator that there were clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of resident, whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is always part of the plan of care and ongoing reporting.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraints were documented on the Glenwood restraint assessment form which included all requirements of the Standard. The RN or CNL undertakes the initial assessment, with input from the resident's whānau/EPOA. The CNL interviewed described the documented process. The general practitioner or nurse practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the two residents' records reviewed of residents who were using a restraint.</p>

<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised, and the CNL described how alternatives to restraints are discussed with staff and family members. They described the use of sensor mats and low beds being tried first.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. All processes ensure dignity and privacy are respected.</p> <p>A restraint register is maintained, updated every month and showed how two residents were no longer requiring the use of a restraint for their safety. The register was reviewed and contained all residents currently using a restraint and enough information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, at least six monthly. There is a Glenwood restraint evaluation form used which meets the requirements of the standard including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required. The form is signed off by the CNL, GP or nurse practitioner and discussed with the resident, whānau/EPOA</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The CNL, when taking on the restraint coordinator role, undertook a review of all restraint in use which included all the requirements of this Standard. The quality, health and safety, management group meeting minutes showed restraint use being discussed; however, no documentation of a review of systems was sighted. This was discussed with the management team.</p> <p>Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. The FM reports on restraint use in her monthly report to the DoN and CE which allows for analysis and trending. Six monthly restraint audits are scheduled.</p> <p>Interviews with the CNL and review of the restraint register confirmed that the use of restraint has been reduced by two since the CNL took over the role.</p>



## Specific results for criterion where corrective actions are required

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

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

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

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

No data to display
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End of the report.