

Annie Brydon Complex Limited

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 Health Audit (NZ) 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:

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| Legal entity: | Annie Brydon Complex Limited |
| Premises audited: | Annie Brydon Resthome and Hospital Te Mahana Resthome |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 20 January 2016 End date: 22 January 2016 |
| Proposed changes to current services (if any): | None |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 80 |

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 |
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|  | 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 |
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| Yellow | 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 |
| Red | 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

Annie Brydon Complex and Te Mahana Rest Home provide residential care for up to 88 residents at two facilities. Annie Brydon Complex provides residential accommodation for up to 68 residents who require hospital and rest home level care and occupancy on day one at Annie Brydon Complex was 62. Eighteen of the beds at Annie Brydon Complex have been approved as dual purpose beds that are able to be used for hospital or rest home level care.

Te Mahana Rest Home provides rest home care for up to 20 rest home residents and occupancy was 18. Both facilities are operated by Annie Brydon Complex Limited. The residents and families reported they are positive about the care provided.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the service's contract with the District Health Board (DHB). The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, families, management, staff and two general practitioners.

The two areas identified as requiring improvement during the last audit have been addressed.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Staff demonstrate an understanding of residents' rights and obligations. Information regarding residents' rights, access to interpreter services and how to lodge a complaint is available to residents and their families. The complaints register is current and all complaints have been entered. There have been no investigations by external agencies since the last certification audit.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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Annie Brydon Complex Limited is the governing body and is responsible for the service provided at Annie Brydon Complex in Hawera and at Te Mahana Rest Home (Te Mahana) in Patea. A business plan and a quality and risk management plan were reviewed. The managers at both facilities provide a monthly written report to the governing body.

One of the directors is the manager at Annie Brydon Complex. They are supported by a clinical nurse manager who is a registered nurse. Oversight of the clinical services provided at both sites is provided by the clinical nurse manager at Annie Brydon Complex. Te Mahana is managed by a non-clinical manager who is supported by one of the directors who is a registered nurse as well as by the other directors. Each director has designated areas of responsibility and work on site at Annie Brydon Complex.

Clinical indicators are reported in monthly quality reports. There is an internal audit programme and audits are completed. Risks are identified and there is a hazard register. Adverse events are documented on accident/incident forms. Internal audits, infection

control surveillance, accident/incident forms, meeting minutes and surveys evidence comprehensive analysis of data and corrective action plans are developed to address any issue/s that require improvement. The improvement identified during the last audit relating to documenting corrective action plans to address areas identified as requiring improvement has been met.

Numbers of various clinical indicators and quality and risk issues are reported via the quality and staff meetings. Graphs of clinical indicators are available for staff to view along with meeting minutes.

There are policies and procedures on human resource management. Staff files evidence job descriptions, orientation, performance appraisals, and police vetting. Current practising certificates are held on files for all health professionals who require them to practice.

An in-service education programme is provided for staff monthly. Caregivers are also required to complete the New Zealand Qualifications Authority Unit Standards. All clinical staff have completed appropriate competencies and these are current.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The managers at both sites and clinical nurse manager are rostered on call after hours. Care staff interviewed reported there is adequate staff available.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |
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Residents' needs at both facilities are assessed on admission by a registered nurse. A previous corrective action to ensure assessments by enrolled nurses at Annie Brydon Complex are signed off by the registered nurse has been addressed. All residents' files sighted provided evidence that needs, goals and outcomes are identified and reviewed on a regular basis. An area previously identified at Te Mahana rest home for reassessment of residents requiring a higher level of care, has also been

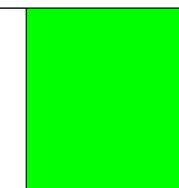
addressed. Residents and families interviewed at both facilities reported being well informed and involved, and that the care provided is of a high standard.

Both facilities have activities programmes that include a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted are consistent with these documents.

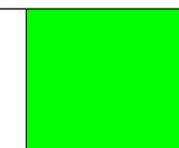
The menu has been reviewed by a registered dietitian as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents have a role in menu choice. The interviews with residents verified satisfaction with meals.

Safe and appropriate environment

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

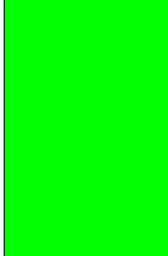
Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |
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The organisation has processes in place for determining safe and appropriate restraint and enabler use. Policy identifies that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety.

The care staff in both facilities demonstrated knowledge and understanding of safe restraint management processes, including enabler use.

Infection prevention and control

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| <p>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.</p> |  | <p>Standards applicable to this service fully attained.</p> |
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Surveillance of infections is occurring as described in the infection control programme. Data on the nature and frequency of identified infections has been collated and analysed. The results of surveillance are reported across all levels of the organisation, including governance.

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 | 17 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 42 | 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 |
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| <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 facility manager at each site is responsible for the management of complaints, with support from the quality manager. There are appropriate systems in place to manage the complaints processes. The complaints registers are current and evidenced three written and verbal complaints received for 2015 at Annie Brydon Complex and none at Te Mahana. Documentation showed all complaints have been investigated and complainants provided with responses in a timely manner and that the complainants were satisfied with the outcome of the complaint.</p> <p>The facility managers advised there have been no investigations by the Ministry of Health, DHB, Health and Disability Commissioner, Accident Compensation Corporation (ACC), Coroner or Police since the previous certification audit.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Systems are in place that ensure residents and their families are advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Residents are able to raise any issues during the resident meetings. Residents and families interviewed and review of resident meeting minutes confirmed this. Review of the collated resident surveys for 2015 evidenced residents knew the process for making a complaint.</p> <p>The complaint process and forms were observed to be readily accessible and displayed. Quality and staff meeting minutes evidence reporting of any complaints as an agenda item. Care staff confirmed information was reported to them via their staff meetings.</p> |

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| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>A review of accident/incident forms showed timely and open communication with residents/family members. Communication with family members is recorded in the resident's file. Family members expressed satisfaction with how well they were kept informed about any change to the resident's condition and their involvement in resident care planning. Residents' meetings are held monthly at Te Mahana and two monthly at Annie Brydon Complex and minutes were reviewed.</p> <p>The facility managers at both sites advised that interpreters are able to be accessed from the interpreter services or family members if required. This information is also provided to residents/families as part of the information/admission pack.</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>Annie Brydon Complex Limited (ABCL) is the governing body and is responsible for the services provided at these two facilities. A business plan was reviewed that includes a mission, values statement, vision, purpose, intent, strengths, goals and opportunities. A quality plan was also reviewed.</p> <p>The newly appointed facility manager, who is not a registered nurse, has worked at Annie Brydon The previous manager at Annie Brydon Complex, who is a registered nurse (RN), has retired and has been replaced by one of the other directors as the facility manager. Complex since 1996. The manager is supported by a clinical nurse manager (CNM), who is an experienced RN. The CNM was appointed as clinical nurse leader in December 2013 and as CNM early January 2016, when the RN director retired. The CNM is responsible for the management of clinical care for residents at Annie Brydon Complex. The management team also includes an experienced quality manager as well as an RN and an enrolled nurse (EN) who are care co-ordinators of each of the two units at Annie Brydon Complex.</p> <p>Te Mahana is managed by a non-clinical manager who was appointed to this position in December 2006. The Te Mahana manager has extensive experience in the aged care sector. The facility manager and CNM from Annie Brydon also provide support for the manager at Te Mahana. The RN director is also providing support two days a week until a newly appointed RN starts the week following this audit.</p> <p>The directors work on site at Annie Brydon and each one has designated areas of responsibility. Organisational charts were reviewed for Annie Brydon Complex and Te Mahana.</p> <p>The annual practising certificate for the CNM, RN director and the newly appointed RN at Te Mahana are current. There was evidence on both facility manager's and clinical nurse manager's files of ongoing education.</p> <p>Documented values, mission statement and philosophy were also reviewed and these are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> |

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| | | <p>Annie Brydon Complex occupancy during this audit was 13 hospital level residents and 49 rest home level care residents. There were 18 rest home residents at Te Mahana including one resident under the age of 65 years.</p> <p>Annie Brydon Complex Limited has contracts with the DHB to provide aged related residential care and chronic health conditions at Annie Brydon and Te Mahana and residential respite services at Annie Brydon.</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> | <p>FA</p> | <p>A quality and risk plan is used to guide the quality programme and includes goals and objectives.</p> <p>An internal audit programme is in place and internal audits completed in 2015 were reviewed, along with processes for identification of risks. Risks are identified, and there is a hazard register at each site that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures. Planned maintenance and calibration programmes are in place and are reviewed. All biomedical equipment has appropriate performance verified stickers in place and/or calibration reports.</p> <p>One of the directors is responsible for coordinating the quality and risk management programme at Annie Brydon and Te Mahana. The director is supported by a full time quality manager who is employed to oversee the quality and risk management programmes at these two facilities as well as at another facility owned by the directors.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Quality improvement data includes: adverse event forms; internal audits and meeting minutes and evidenced corrective action plans are being developed, implemented, monitored and signed off as being completed. The improvement identified during the last audit relating to documenting corrective action plans has now been met.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed they are advised of updated policies and that they provide appropriate guidance for the service delivery.</p> <p>Staff interviewed report they are kept informed of quality and risk management issues including clinical indicators. Staff interviewed report this information is discussed with them at hand-over between shifts and during their meetings. This information is also reviewed in the staff newsletters. Copies of meeting minutes are available for staff to review in the staff offices and include graphs of clinical indicators.</p> <p>Resident satisfaction surveys are completed monthly and collated results are reviewed. Different residents/family members are surveyed each month and the results are collated at the end of each month. The results are</p> |

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| | | <p>reported via the monthly quality meetings and staff meetings and the managers' reports. Feedback is also provided to residents via their meetings. Any areas identified as requiring improvement during these surveys are addressed immediately. Month by month comparisons are made of the residents' feedback and review of this data and individual responses indicates high levels of resident satisfaction. A 'short term and post admission follow-up survey' of residents is also undertaken and the results for 2015 were reviewed during this audit.</p> <p>Resident meetings are held two monthly in each of the two units at Annie Brydon Complex as well as monthly at Te Mahana Rest Home.</p> |
| <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 document adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the clinical nurse manager at Annie Brydon Complex; and by the RN/director and the manager at Te Mahana. These are signed off when completed. Corrective action plans to address areas requiring improvement are documented on accident/incident forms. The registered nurses undertake assessments of residents following an accident at Annie Brydon Complex. The RN/director assesses all residents at Te Mahana who require an RN assessment following an adverse event. The GP and practice nurses from the health centre in Patea are available if required at Te Mahana to assess residents. The manager at Te Mahana advised staff contact the ambulance service if required. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they complete accident/incident forms for adverse events. Policy and procedures comply with essential notification reporting, for example: health and safety; human resources; infection control. The managers at both facilities reported they are aware of their responsibilities concerning essential notifications.</p> <p>Resident's files reviewed as well as accident and incident forms, residents progress notes, and family communication sheets provided evidence that communication/contact with family is being documented following adverse events (as appropriate) involving the resident, or when there is any change in the resident's condition. Family members advised they are contacted if their family member has an accident/incident, and/or if there is any change in their condition. This finding was confirmed during review of the satisfaction surveys.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p> | FA | <p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.</p> |

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| <p>accordance with good employment practice and meet the requirements of legislation.</p> | | <p>The clinical nurse manager (CNM) at Annie Brydon Complex and the manager at Te Mahana are responsible for management of the in-service education programme at each facility.</p> <p>The education planners for 2015 and 2016 were reviewed and education is provided at least monthly. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided and staff attendance is high. There is a suite of competency assessments that staff are required to complete as appropriate, including a wound care and pressure area competency. Competency assessment questionnaires are current for medication management and restraint. The clinical nurse manager and other RNs have the required interRAI assessments training and competencies.</p> <p>All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers.</p> <p>An appraisal schedule is in place and current staff appraisals were in the staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.</p> <p>Care staff confirmed they have completed an orientation, including competency assessments (as appropriate). Care staff also confirmed their attendance at on-going in-service education and the currency of their 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 is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided 24 hours, seven days a week at Annie Brydon Complex. On call after hours is provided by the facility manager, the clinical nurse manager and the directors. The minimum number of staff on duty is during the night and consists of a registered nurse (RN) and two caregivers at Annie Brydon Complex, and one caregiver at Te Mahana.</p> <p>There are 24 serviced apartments at Annie Brydon Complex with Occupational Rights Agreement (ORA) in place. These ORA units are contained within the rest home parts of the facility. Twenty two of these serviced apartments are occupied by residents who are assessed as rest home level care. Additional staff is rostered on to care for these residents.</p> <p>The clinical nurse manager is available after hours for clinical issues, and the facility manager for business/administration issues if required at Annie Brydon Complex. The director/RN and the manager from Te Mahana are also available after hours if required. Care staff from Te Mahana also contact the RNs at Annie Brydon Complex for advice if required.</p> <p>The service provider uses a 'Models of Care' tool that allocates a set number of care staff hours per resident in</p> |

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| | | <p>the rest home and in the hospital that is based on best practice.</p> <p>Staff interviewed reported there is adequate staff available and that they are able to get through their work. All registered and enrolled nurses and the activities co-ordinator have a current first aid certificate. Residents and family interviewed reported staff provide them with adequate care. Observations during this audit confirmed adequate staff cover was provided.</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>In both facilities, the medication management policy is comprehensive and identifies all aspects of medicine management.</p> <p>A safe system for medicine management was observed in both sites on the days 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>Where used, controlled drugs, are stored in separate locked cupboards, and checked by two nurses for accuracy in administration. The controlled drug register evidences weekly and six monthly stock checks and accurate records.</p> <p>The record of temperatures for the medicine fridges has readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart at Annie Brydon. The GP at Te Mahana reviews residents' medication monthly as part of the monthly review and this is recorded on the medicine chart.</p> <p>Residents' who self-administer their medicines have appropriate processes in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and recorded on an 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 is verified.</p> <p>Standing orders are not used at Te Mahana. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident's medication chart. PRN medication requests include indications for use.</p> <p>Standing orders are used at Annie Brydon, and documentation is compliant with guidelines. Each residents' three monthly medication review incorporates a review and authorisation for the use of standing orders.</p> |

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| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>In both facilities, the food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menu in July 2015.</p> <p>A dietary assessment is undertaken for each resident on admission to each facility and a dietary profile is developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p> <p>A cleaning schedule was sighted as is verification of compliance.</p> <p>Evidence of resident satisfaction with meals at both facilities is verified by resident and family/whanau interviews, sighted satisfaction surveys and resident meeting minutes.</p> <p>There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | <p>FA</p> | <p>On admission to either facility, residents have their needs identified through a variety of information sources that include; the needs assessment and service coordination (NASC) agency; other service providers involved with the resident; the resident; family/whanau and on-site assessments using a range of assessment tools. The information gathered by the RN, or enrolled nurse (EN) at Annie Brydon with RN oversight, is documented and informs the initial care planning process.</p> <p>Over the next three weeks, the RN undertakes an interRAI assessment, and other assessments as clinically indicated, which are reviewed six monthly or as needs, outcomes and goals of the resident change. An area previously identified at Te Mahana rest home for reassessment of residents requiring a higher level of care, has been addressed.</p> <p>A medical assessment is undertaken within 24 hours of admission and reviewed as a resident's condition changes, monthly or three monthly (at Annie Brydon) if the GP documents the resident is stable. A multidisciplinary assessment is undertaken yearly.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive</p> | <p>FA</p> | <p>At both facilities documentation including interventions, observations and interviews verified the provision of care provided to residents is consistent with residents' needs and desired outcomes.</p> <p>Residents and family/whanau members expressed satisfaction with the care provided.</p> |

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| adequate and appropriate services in order to meet their assessed needs and desired outcomes. | | There is sufficient supplies of equipment seen to be available that complies with best practice guidelines and meets the residents' needs. |
| <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>At both facilities, residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programmes sighted match the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.</p> <p>Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verify feedback is sought and satisfaction with the activities offered.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>At both facilities, resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN.</p> <p>Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the service delivery plan.</p> <p>A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident's general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews at sites, verified residents and family/whanau are included and informed of all 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</p> | FA | Current building warrants of fitness are displayed that expire on the 15 October 2016 (Annie Brydon Complex) and 26 August 2016 (Te Mahana). |

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| for their purpose. | | |
| <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>Monthly surveillance of infections is occurring in line with the infection prevention and control policy and procedures. The surveillance data is collated each month and analysed to identify any significant trends or possible causative factors.</p> <p>Incidents of infections are presented at the quality meetings and staff meetings. Any ongoing corrective actions are discussed and presented at quality, registered nurse and staff meetings. This was confirmed during review of meeting minutes, infection surveillance records and staff interviews. If immediate action is required, this information is relayed to staff at hand over of shift.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>Policy and procedures are in place in both facilities to ensure any restraint use is actively minimised. Policy identifies enablers are voluntarily used by a resident following appropriate assessment. The restraint register at Annie Brydon identifies when restraints or enablers are commenced and when they are stopped if no longer required. There were no residents at Te Mahana using restraints or enablers.</p> <p>Staff interviews, at both facilities, confirm their knowledge of enablers and understanding of safe restraint use.</p> |

Specific results for criterion where corrective actions are required

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

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

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

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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.

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End of the report.