

# Prasad Family Foundation Limited

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Prasad Family Foundation Limited
<b>Premises audited:</b>	Brylyn Residential Care
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 13 February 2017      End date: 14 February 2017
<b>Proposed changes to current services (if any):</b>	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	25

# 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

Brylyn Residential Care is owned and operated by the Prasad Family Foundation Limited. The service provides cares for up to 32 residents requiring hospital and/or rest home level care. On the day of the audit, there were 25 residents.

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

The service is overseen by a nurse manager/registered nurse who has been in the role 2.5 years. Residents and family spoke positively about the service provided.

This audit has identified a number of system and process failures around quality and risk management. The following areas for improvement are identified; policies and procedures, document control, implementation of the quality and risk management programme, health and safety, human resources and management; service provider availability, storage of resident information, admission agreements, InterRAI, care planning, interventions, evaluations, medication management, medication competencies, chemical safety, provision of personal protective equipment, maintenance, call bells, first aid training and trial evacuations.

## 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.
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Staff at Brylyn Residential Care strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Residents and staff have access to Health and Disability Commissioner's Code of Consumers' Rights. Policies are documented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Complaints and concerns have been managed and a complaints register is maintained.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a documented quality and risk management programme that is not fully implemented. Adverse events are documented. There are documented human resource policies and an annual training plan. A health and safety plan is documented.

Registered nursing cover is provided 24 hours a day, seven days a week. A nurse manager/registered nurse is responsible for the day-to-day operations of the facility and resident care, as a registered nurse 4 days per week. Residents receive services from suitably qualified staff.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is an admission package on services and levels of care provided at Brylyn rest home and hospital. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan, documenting supports, needs, outcomes and goals with the resident and/or family/whānau input. The general practitioner reviews the residents at least three monthly and earlier if required.

Medication policies reflect legislative requirements and guidelines. Registered nurses and senior caregivers administer medicines. The medicine charts reviewed had photo identification and allergy status identified. The medication charts had been reviewed at least three monthly.

An activity coordinator coordinates and implements the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The menu has been reviewed by a dietitian. Food, fluid, additional requirements/modified needs and dislikes were being met.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There are documented processes for the management of waste and hazardous substances in place. The building holds a current warrant of fitness. Residents can freely mobilise or be transported safely within the communal areas. There is safe access to the outdoors, seating and shade. Resident bedrooms are personalised with ensuites or access to communal facilities. Cleaning and laundry services are completed on site. Systems and supplies are in place for essential, emergency and security services.

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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Brylyn Residential Care has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents using restraint or enablers.

## Infection prevention and control

<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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The nurse manager is the infection control coordinator. There is a suite of current policies and procedures.

## 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	32	0	4	9	0	0
<b>Criteria</b>	0	69	0	11	13	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>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (four caregivers, two registered nurses (RN), one activities coordinator, and one nurse manager/registered nurse) confirm their familiarity with the Code. Interviews with six residents (four rest home and two hospital) and two families (one rest home and one hospital) confirm the services being provided are in line with the Code.</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>There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission and sighted in five of five resident files reviewed (two hospital and three rest home). Advance directives for continuing care (where appropriate) were completed and on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. Copies of EPOA were in resident files where required.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers and registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent</p>

		<p>processes.</p> <p>Relatives and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided.</p> <p>All resident's files sampled had signed admission agreements on file.</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>	FA	<p>A policy describes access to advocacy services. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocacy support is available if requested. No training records could be located to identify when staff last received training on advocacy services (link 1.2.7.5). Interviews with staff and residents confirmed they are aware of advocacy and how to access an advocate.</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>	FA	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. Residents are encouraged to be involved in community activities and maintain family and friend's networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</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>	FA	<p>The service has a complaints policy that describes the management of complaints process. There is a complaint form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed could describe the process around reporting complaints.</p> <p>There is a complaint register. Written complaints are documented. There have been three complaints since the last audit. All complaint documentation was reviewed. All three complaints had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer. Details relating to the Code and how to access advocacy services are also included in the resident information pack provided to new residents and their family/whānau. The nurse manager/registered nurse discusses aspects of the Code with residents and their family on admission.</p> <p>All six residents interviewed (four rest home and two hospital) and two families interviewed (one hospital and one rest home) confirmed the residents' rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care.</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>The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. The residents' personal belongings are used to decorate their rooms. All rooms were single occupancy during the audit. Adequate space is available for discussions of a private nature. The caregivers interviewed report that they knock on bedroom doors prior to entering rooms, and ensure doors are shut when cares are being given. Staff were observed knocking on doors before entering the resident rooms during the audit. All residents interviewed confirmed that their privacy is being respected.</p> <p>Not all resident's private information was being kept secure (link 1.2.9.7).</p> <p>Guidelines on abuse and neglect are documented in policy. Staff last received training on abuse and neglect prevention in April 2015 (link 1.2.7.5). The nurse manager/registered nurse is unaware of any suspected instances of abuse or neglect by staff.</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>The staff interviewed could describe how Māori interests, customs, beliefs, cultural and ethnic backgrounds are valued and fostered within the service. A Maori health plan is in place. Links are established with local Māori agencies.</p> <p>Staff value and encourage active participation and input of the family/whānau in the day-to-day care of residents. The service has a number of Māori staff who facilitate links with local Māori community groups. The Māori staff interviewed advised that they provide support and guidance to all staff on the cultural and spiritual requirements of Māori residents. Two residents identified as Māori on the day of the audit and confirmed on interview that their cultural needs were being met. However, their cultural and spiritual needs were not documented in their care plans (link 1.3.5.2).</p>

		<p>Discussions with staff confirm that they are aware of the need to respond to cultural differences.</p> <p>Staff last received training on cultural awareness in July 2015 (link 1.2.7.5). All care staff interviewed are aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including resident's cultural beliefs and values, is not always being documented in the care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. One resident who identified with another ethnicity did not have their cultural and spiritual needs documented in their care plan (link 1.3.5.2). The resident was bilingual and posters were up in the dining room in the resident's first language. The resident was interviewed and stated they were happy with the care they received.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>House rules are documented and discussed with new employees. Professional boundaries are defined in job descriptions. Interviews with all care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers' role and responsibilities. The RNs supervise staff to ensure professional practice is maintained in the service. Professional boundaries are reconfirmed through performance management if there is infringement with the person concerned. The abuse and neglect processes cover harassment and exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs (link 1.2.3.3). Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Residents interviewed spoke very positively about the care and support provided. Staff interviewed understood the principles of aged care and stated that they feel supported by the nurse manager/registered nurse.</p> <p>Registered nursing staff are available seven days a week, 24 hours a day. A general practitioner (GP) visits the facility once a week. A physiotherapist visits as required. The GP interviewed is satisfied with the level of care that is being provided. This audit has identified a</p>

		number of system and process failures around quality and risk management (link 1.2.3).
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Seven incidents/accidents forms were reviewed. The forms included a section to record family notification. All incident forms reviewed indicated family were informed of the adverse event. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</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>	FA	<p>Brylyn Residential Care provides care for up to 32 residents. Twenty two beds are certified for rest home level care and ten beds are certified for hospital level care. At the time of the audit, there were sixteen rest home residents and nine hospital level residents. All residents on the day of audit were admitted under the ARRC contract. One rest home resident was not a New Zealand citizen and was paying privately.</p> <p>Brylyn Residential Care is privately owned. A business plan and a quality and risk management plan are in place. The business plan identifies scope, direction and goals of the service.</p> <p>The nurse manager/registered nurse has a current practising certificate, and has been in the current role since November 2014. The nurse manager/registered nurse currently works as the only RN on the floor four days per week, and has one day per week to complete the management responsibilities. The nurse manager/registered nurse is also the infection control coordinator, the restraint coordinator, the staff educator and is required to implement all aspects of the quality management programme. The owner completes the financial management and the nurse manager/registered nurse completes all other reception and administration tasks. The nurse manager/registered nurse advised that due to conflicting priorities she does not always have time to complete what is required (link1.2.8.1).</p> <p>The nurse manager/registered nurse meets fortnightly with the owner and has attended eight hours of professional development relating to the management of an aged care facility in the past 12 months.</p>

<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>	<p>FA</p>	<p>In the absence of the nurse manager/registered nurse, a registered nurse is in charge with support from the owner and the other registered nurses and care staff.</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>PA Moderate</p>	<p>Brylyn Residential Care has a documented quality management system. There are documented policies and procedures to guide staff however; not all policies and procedures required have been documented and not all policies documented reflect current best practice. There is evidence of organisational documents being reviewed but no evidence of a formalised document control programme. Staff have access to the manuals.</p> <p>The nurse manager/registered nurse understands the quality and risk management programme and advises that due to the administrative and clinical requirements of the role the quality management system has not been fully implemented. An internal audit schedule is in place but not all scheduled audits have been completed.</p> <p>Data is collected for falls, skin tears, medication errors and infections. This information is collated and trended but is not consistently analysed, and evaluated and used for service improvements. Corrective actions are not consistently documented where quality data identifies opportunities for improvements and corrective actions have not been communicated to staff or signed off when implemented. Not all scheduled site meetings have been held.</p> <p>Falls prevention strategies are in place on a case-by-case basis, which includes the use of sensor mats and utilisation of physiotherapy services. The service has a high incidence of falls; however there was no evidence of a falls reduction strategy for the service.</p> <p>Staff interviewed were able to describe the principles of hazard management; however the health and safety system has not yet been fully implemented.</p> <p>Residents are surveyed to gather feedback on the service provided. The results of the resident survey completed in December 2016, have not been communicated to the residents and where improvements are indicated, corrective actions have not been documented or implemented. The 2016 survey indicated satisfaction with the service.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The nurse manager/registered nurse</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>investigates accidents and near misses. There is a lack of documented evidence to reflect accident and incident information is being communicated to staff (link 1.2.3.6).</p> <p>A registered nurse conducts clinical follow-up of residents, however clinical assessments following unwitnessed falls were not fully documented (link 1.3.6.1). Seven incident forms sampled demonstrated that family were notified following adverse events.</p> <p>Discussions with the nurse manager/registered nurse confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Appropriate notification was made around a norovirus outbreak in May 2016.</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>PA Moderate</p>	<p>There are human resources policies to support recruitment practices, orientation and staff training and development. The orientation programme provides new staff with relevant information for safe work practice. Not all staff have completed the organisational orientation programme. Staff interviewed stated that not all new staff are adequately orientated to the service.</p> <p>Six staff files were reviewed (one nurse manager/registered nurse, one registered nurse, two caregivers, a cook and maintenance). Missing was evidence of completed orientation documentation, performance appraisals, and visa documentation.</p> <p>Current practising certificates were sighted for the registered health professionals.</p> <p>There was no documented education plan for 2016 or 2017. Toolbox talks at handover have recently been reintroduced. Not all required education has been completed and not all staff have completed the required competencies (link 1.3.12.3 and 3.4).</p> <p>The nurse manager/registered nurse and the registered nurses can attend external training, including sessions provided by the local DHB. The registered nurse trained in the use of InterRAI is currently on leave until July 2017. On the day of audit there were no registered nurses trained in the use of the InterRAI. One registered nurse is currently completing the training and another is enrolled in a course to commence next month.</p> <p>Staff first aid training is required (link to 1.4.7.1) and food safety training has not been completed for all staff working in the kitchen.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>PA Moderate</p>	<p>There is a documented staffing policy and there is a registered nurse rostered on each shift. The nurse manager/registered nurse carries a full clinical registered nurse load four mornings per week. The nurse manager reports that the time spent working as an RN on the floor makes</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>it difficult to complete the managerial responsibilities and tasks required. There are insufficient hours allocated to the management and leadership aspects of the service.</p> <p>There is one registered nurse and two caregivers on the afternoon shift. One afternoon caregiver is required to work in the kitchen from 1530 to 1830 and is not available for resident cares during this time. The care staff interviewed report that there are insufficient staff available to meet the needs of all the residents from 1530 to 1800. The laundry is completed by the afternoon caregivers after the residents have gone to bed. The caregivers interviewed confirmed that they have enough time to complete the laundry</p> <p>There is one RN and one caregiver on the night shift. A dedicated cleaner works 7 days per week.</p> <p>Interviews with staff, residents and family members identify that staffing is adequate on a morning and night shift to meet the needs of residents.</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>PA Low</p>	<p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Residents' files demonstrate service integration. Entries are legible, and are dated and signed by the relevant caregiver or nurse, including designation. Information containing personal resident information is not being kept confidential and current residents and archived files are not protected from unauthorised access.</p>
<p>Standard 1.3.1: Entry To Services</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>PA Low</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs are provided for families and residents prior to or on admission. Five admission agreements for long-term residents had been signed on admission, however the agreement does not align with all 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>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</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>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Not all registered nurses and senior caregivers who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has not been provided. Medications are delivered in blister packs and all medications are stored safely. The RN checks the medications against the medication chart and signs the blister pack. Standing orders are not used and all medications are prescribed for the resident. Expired medications are checked regularly with the exception of the antibiotic stock for GP. There were no residents self-medicating on the day of audit. All eye drops are dated on opening.</p> <p>All 10 pharmacy generated medication charts reviewed (four hospital and six rest home) had photo identification and allergy status identified. The GP has reviewed the medication charts three monthly. The prescribing on five of 10 medication charts did not meet legislative requirements.</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>	<p>FA</p>	<p>All meals and baking is prepared and cooked on site by cooks. The cleaners prepare breakfast before commencing cleaning duties. A caregiver is assigned tea shift duties from 3.00pm to 6.30pm. There is a four-week seasonal menu in place which had been reviewed by a dietitian February 2016. Meals are served directly from the kitchen to residents' in the dining room. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, cultural and religious food preferences are met. Additional or modified foods are also provided by the service. Special diets provided include gluten free.</p> <p>Fridge, freezer and end cooked temperatures are monitored daily. A kitchen cleaning schedule is in place and implemented. Not all food service staff have attended food safety training (link 1.2.7.5).</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 is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</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>The RN completes an initial assessment on admission including risk assessment tools. An InterRAI assessment is undertaken within 21 days of admission. Resident needs and supports are identified through the ongoing assessment process in consultation with significant others. InterRAI assessments, assessment notes and summary were in place for new admissions and six monthly reviews for three of the five resident files sampled (link 1.3.3.3).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Resident lifestyle plans reviewed were resident focused and individualised for one of five resident files reviewed. Acute care plans were used for short-term needs (link 1.3.6.1). Lifestyle plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration and evidence of allied healthcare professionals involved in the care of the resident such as the physiotherapist and mental health services.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications were documented on the family/whānau contact sheet in the resident files.</p> <p>Adequate dressing supplies were sighted in the treatment room. Wound assessments, treatment and evaluations were in place for current wounds and skin tears. There was one stage-three facility acquired pressure injury on the day of audit. There is adequate pressure prevention injury equipment available. The RNs interviewed were able to describe the referral process for a wound care nurse specialist if required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission.</p> <p>Acute care plans document appropriate interventions to manage short-term changes in health, however there was no acute care plan in place for one resident with weight loss. Neurological observations had not been completed for unwitnessed falls (link 1.2.4).</p>

<p><b>Standard 1.3.7: Planned Activities</b></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>	<p>FA</p>	<p>The service employs an activities coordinator for 25-30 hours per week to provide an integrated rest home and hospital activity plan Monday to Friday from 9.00am to 2.30pm. The activity coordinator is progressing through the diversional therapy qualification and has a current first aid certificate.</p> <p>Activities are held in the main lounge and were observed to occur as per the programme on the days of audit. There is a variety of activities that meets the abilities of all residents including daily exercises to music, board games, crafts, newspaper reading and celebrating events such as Valentine's Day. One-on-one time is spent with residents who choose not to join in group activities or are unable to participate in activities. Entertainers providing entertainment and music attend the home in the weekends. Interdenominational church services are held on-site fortnightly. Families are invited and welcome to become involved in the activity programme with their relative. The service hires rental vans with wheelchair access for outings into the community.</p> <p>An activity assessment and plan is completed on admission in consultation with the resident/family (as appropriate) and reviewed six monthly.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>All initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term lifestyle plans have been reviewed at least six monthly or earlier for any health changes. The written evaluation documents the resident's progress against identified goals. The GP reviews the residents at least three monthly or earlier if required. The multidisciplinary review team includes the RN/primary nurse, nurse manager/registered nurse, caregivers and the resident/relative and any other allied health professional involved in the care of the resident. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Acute care plans reviewed did not evidence written evaluations.</p>
<p><b>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</b></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>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p> <p>There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</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>PA Moderate</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets are available for staff. Not all chemical bottles sighted in the locked chemical cupboard have manufacturer labels. Chemical bottles were seen in showers and toilets on the day of audit. Gloves were seen to be appropriately worn by staff carrying out their duties however personal protective clothing was not always available.</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>PA Moderate</p>	<p>The building has a current building warrant of fitness that expires 20 September 2017.</p> <p>The service employs a part-time maintenance person for 2.5 hours per day and maintenance assistant for five hours per day. A maintenance log book (sighted) is completed for maintenance requests and signed-off as addressed. Planned maintenance includes interior and exterior maintenance but not all environmental maintenance had been completed. Resident equipment such as hoists and weighing scales had been calibrated annually. Not all electrical equipment had been tested and tagged. Essential contractors are available 24 hours as required. Hot water temperature monitoring is checked randomly in resident rooms and communal facilities. Temperatures are maintained less than 45 degrees Celsius.</p> <p>The facility corridors have sufficient wide enough space for residents to safely mobilise using mobility aids or in lazy boy chairs, with the assistance of staff.</p> <p>There is safe access to the outdoor areas with rails and ramps in place. Seating and shade is provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>Toilet and shower facilities are of an appropriate design to meet the needs of the residents (link 1.4.2.1). Some resident rooms including the studio rooms have ensuites. There are adequate numbers of communal toilets and shower rooms including one large enough for the use of a shower trolley. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p>
<p>Standard 1.4.4: Personal Space/Bed</p>	<p>FA</p>	<p>All resident rooms are single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are</p>

Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		encouraged to personalise their rooms. This is evident on audit.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas within the facility include separate dining room which is partitioned to provide privacy for dependent residents, a main lounge and smaller family lounge. Seating and space is arranged to allow both individual and group activities to occur. All communal areas are easily accessible for residents.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There a lack of procedures to provide guidelines regarding the safe and efficient use of laundry services (link 1.2.3.3). There are dedicated cleaning staff seven days a week. All linen and personal clothing is laundered on-site. There are commercial washing machines and dryers. The laundry has a defined clean/dirty area. The cleaner's trolley is well equipped. Cleaning equipment is colour coded for specific areas. The cleaner's trolley is kept in the locked laundry when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was not sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff. Emergency management competencies are required to be completed (link 1.2.7.5). Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place.  There is not a minimum of one person trained in first aid available at all times.  There are call bells in the residents' rooms, and lounge/dining room areas. Not all call bell call points could be reached by the residents when in bed and not all call points had cords.
Standard 1.4.8: Natural Light, Ventilation,	FA	Residents are provided with adequate natural light, safe ventilation, and an environment that is

<p>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>		<p>maintained at a safe and comfortable temperature. There are opening windows for ventilation. Heat pumps and air conditioning units are used in communal areas. There are electric wall heaters in resident rooms (link 1.4.2.1). All bedrooms have good sized windows which allows plenty of natural light.</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>	<p>FA</p>	<p>The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control programme is reviewed annually. The infection control coordinator is the nurse manager/registered nurse and is responsible for infection control across the facility. The infection control coordinator provides infection control reports to the two-monthly staff meeting (link 1.2.3.6).</p> <p>Visitors are asked not to visit if unwell. There are sufficient hand sanitisers placed throughout the facility. Residents and staff are offered the influenza vaccine.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Brylyn Rest home and Hospital. The nurse manager/registered nurse has taken on the role to cover leave for the RN/infection control coordinator for seven months. Both infection control coordinators (RN and nurse manager) have not completed education in relation to infection control in the last year (link 1.2.7.5). External resources and support are available through the DHB and public health department when required.</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 infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. The policies reflect current best practice and are reviewed by the nurse manager/registered nurse January 2016. The service has an infection control reference manual that has been developed by an infection control consultant.</p>
<p>Standard 3.4: Education</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene,</p>

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>standard precautions and a hand washing competency is completed (link 1.2.7.4). Infection control training has not been offered annually and not all staff have completed annual hand hygiene competencies (link 1.2.7.5).</p> <p>Resident education is expected to occur as part of the resident daily activities.</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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates infection control events monthly, however the data is not analysed for trends and opportunities for improvement and training opportunities. Individual infection reports and acute care plans are completed for all infections. Definitions of infections are in place, appropriate to the complexity of service provided. There is no documented evidence of trending, analysis or discussion around infection control data at staff meetings (link 1.2.3.6).</p> <p>There has been one outbreak in May 2016. Relevant authorities were notified. Following a debrief, quality improvements implemented included an increase in supplies of personal protective equipment and converting a storeroom into an additional shower room.</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 restraint minimisation and safe practice policies and procedures applicable to the size and type of the service. The restraint policy includes a definition of enablers and procedures for assessment and appropriate use of enablers (that is, voluntary restraint). There are currently no enablers or restraints in use. The restraint coordinator is the nurse manager/registered nurse.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	<p>The service has documented policies and procedures to guide staff, however there are no documented polices or procedures for the operation of the laundry. The policies and procedures are reviewed by the nurse manager/registered nurse, but not all polices have been reviewed within the required timeframes. The policies reviewed reflect current good practice except for the pressure injury policy, which does not align with MOH definitions around the staging of pressure injuries.</p>	<p>i) There are no policies and procedures documented for the operation of the laundry.</p> <p>ii) The Health and Safety policy has not been reviewed annually as required by the Health and Safety policy.</p> <p>iii) The pressure injury policy in use, does not reflect the MOH guidelines on the staging of pressure injures.</p>	<p>i) Ensure that policies and procedures are documented to cover all aspects of the service.</p> <p>ii) Ensure that the policies and procedures are all reviewed within the timeframes required, and are updated as required.</p> <p>iii) Ensure the Pressure Injury policy reflects current best</p>

				practice.  180 days
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	PA Low	<p>The nurse manager/registered nurse described the process that is currently used to review the organisational documents. Currently the nurse manager/registered nurse reads through the organisational documents being reviewed and edits the information as required. The footer is then updated to reflect the next review date. The review process does not involve any consultation with other staff or content experts or communication to staff about any change made. There is no documented process on how to review the organisational documents and the nurse manager/registered nurse advised that the document review cycle is driven by the time the nurse manager/registered nurse has available to complete reviews.</p>	<p>(i) There is no documented process on how to review the organisational documents. (ii) There is no documented policy review schedule. (iii) There is no implemented process around communicating policy changes to staff.</p>	<p>Ensure a document control process and system is documented and implemented.</p> <p>180 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Clinical indicator data is collected each month for falls, skin tears, medication errors and infections. Accident and incident forms are completed by staff, and collated. Accident and incident forms were sighted for the current pressure injuries. Where audits have been completed, the data is collated. Quality improvement data is not consistently trended and analysed to identify opportunities for improvement and the results are communicated to staff. The service has had a high incidence of falls (3-13 falls each month in the past 12 months). Interventions have been implemented on a case-by-case basis however no overall falls prevention/reduction strategy has</p>	<p>i) Quality improvement data is not consistently trended and analysed to identify opportunities for improvement.</p> <p>ii) There is a lack of documented evidence to reflect quality improvement data is being communicated to staff.</p> <p>iii) The results of the resident satisfaction survey completed in December 2016 have not been communicated to the residents.</p> <p>iv) There is no audit scheduled</p>	<p>i-iii) Ensure that all quality improvement data is trended and analysed and the results communicated to staff and residents where appropriate.</p> <p>iv) Ensure there is a scheduled review of the management of wound care and pressure injury management.</p>

		<p>been discussed with staff or implemented.</p> <p>There is no audit scheduled for the review of wound care or pressure injury management.</p> <p>The resident survey completed in December 2016 identified areas requiring improvement. The nurse manager/registered nurse advised that the results of the survey have been discussed with the owner. The results of the survey have not been communicated to the residents.</p> <p>The nurse manager/registered nurse advised that there is only one staff meeting that is held on site, which occurs bi-monthly. This is a general staff meeting to which all staff are invited. This meeting usually has good attendance. Where staff meetings have been held there is no evidence that quality data, trends, complaints, corrective actions, pressure injuries are discussed with staff. The staff interviewed advised that quality data information is not consistently communicated via staff noticeboards or communication books. Resident meetings have been held 3-4 monthly.</p>	<p>for the review of wound management or pressure injury</p> <p>v) Where staff meetings have been held there is no evidence that quality data, pressure injuries trends, complaints, are discussed or consistently communicated to staff.</p>	<p>v) Ensure that all relevant aspects of the quality management system are communicated to staff.</p> <p>90 days</p>
<p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	<p>An internal audit programme is documented, but not all scheduled audits have been completed.</p>	<p>Not all internal audits have been completed as per the audit schedule.</p>	<p>Ensure that the monitoring schedule is fully implemented.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard</p>	PA Low	<p>The service captures quality data. Where areas requiring improvements were noted, corrective action plans were not consistently documented. Where corrective action plans have been developed, these are not consistently evaluated</p>	<p>i) Corrective action plans are not consistently documented where opportunities for improvements are identified.</p> <p>ii) Not all corrective action plans</p>	<p>i-iii) Ensure that corrective actions plans are documented where opportunities for</p>

<p>or requirements is developed and implemented.</p>		<p>and signed out.</p> <p>The resident survey completed in December 2016 identified areas requiring improvement. No corrective actions plans have yet been documented,</p>	<p>are evaluated and signed off when completed.</p> <p>iii) A corrective action plan has not been documented or implemented to address the areas requiring improvement noted in the recent resident survey.</p>	<p>improvement are noted and the corrective action plans are then implemented, reviewed and signed off once completed.</p> <p>90 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	<p>PA Moderate</p>	<p>The service has documented health and safety policies. Health and safety is covered at orientation for new staff. The health and safety representative has attended training on Health Safety and Accident Investigation. The nurse manager/registered nurse has not attended any health and safety training since commencing in the role. Staff have not had any health and safety updates since the last audit. Staff interviewed could describe hazard management practices used on site.</p> <p>Hazard management forms are in use, however not all sections of the hazard forms were fully completed and corrective actions were not always fully documented. There have been three minor staff injuries reported in the past 12 months and these have not been entered on the accident register. The nurse/manager was able to describe the accident investigation process completed, however the accident investigation and the outcomes were not documented.</p> <p>Health and safety audits are scheduled on the annual planner however the scheduled audits have not been completed. There is a health and safety committee, however there have been no</p>	<p>i) The nurse manager has not had any training in Health and Safety management.</p> <p>ii) Staff have not had any training or information about the changes to the Health and Safety legislation that occurred in April 2016.</p> <p>iii) Not all sections of the hazard management form currently in use are fully completed.</p> <p>iv) Where improvements are required for the management of hazards, not all corrective action plans are documented or reviewed for effectiveness.</p> <p>v) Not all staff accidents are logged on the accident register and not all staff accident investigations and their outcomes are documented.</p> <p>vi) Scheduled Health and Safety audits have not been</p>	<p>i) Ensure all staff receive regular training in Health and Safety.</p> <p>ii) Ensure the nurse manager/registered nurse completes training in Health and Safety management.</p> <p>iii-iv) Ensure that all aspects of the health and safety management system are fully implemented.</p> <p>90 days</p>

		<p>monthly health and safety meetings held, as required by the organisational policy. There is no evidence that health and safety and hazard management is being discussed at the staff meetings that have been held.</p> <p>There is a hazard register in place, and hazards have been added to the register from information obtained from the hazard management forms. There is no evidence of when the hazard register was last reviewed.</p>	<p>completed.</p> <p>vii) There have been no monthly health and safety committee meetings as required by the organisational policy.</p> <p>viii) There is and no evidence that health and safety and hazard management is being discussed at the staff meetings that have been held.</p> <p>iv) The hazard register has not been reviewed annually.</p>	
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>There are polices in place which document the recruitment process. The nurse/manager advised that they are responsible for the selection and recruitment of staff. There was evidence in three of three files sampled, for staff employed since the last audit, that reference checks were completed and where required practicing certificates had been sighted. Two of six files sampled were for staff not born in New Zealand. There was no evidence on their staff files that these staff were legally entitled to work in New Zealand. The nurse manager/registered nurse advised that the visa and work permit documentation had not been sighted prior to employment being offered. The staff file sample was extended to include all non-New Zealand born staff working at the facility. During the audit copies of visas and/or work permits were obtained for six staff that did not have copies on their files, however visa and work permit documentation was not seen for all non-New Zealand staff working at the facility.</p>	<p>Three staff that were not born in New Zealand did not have copies of visa and work permit documentation on file.</p>	<p>Ensure that all staff working at the facility are legally entitled to do so, and a copy of relevant immigration documentation is kept on staff files.</p> <p>60 days</p>

<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Moderate</p>	<p>The service has a documented orientation programme. Not all staff have completed the required orientation. The care staff interviewed advised that new staff were not always sufficiently orientated to the requirements of their role. The care staff advised that new caregivers were often not sufficiently trained in how to complete personal care or in manual handling before they were required to work unsupervised on the floor.</p>	<p>Five of six files sampled had no evidence of completion of the orientation programme.</p>	<p>Ensure that the required orientation/induction programme is completed by all staff and evidence of this is kept on staff files.</p> <p>60 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>In 2016 staff were invited to select from a list of possible education topics, the areas that they would like education on. Education was then arranged for the topics selected (including emergency management, manual handling, chemical safety, documentation and diabetic management). There is no documented education planner for 2017. Staff employed since 2015 have not received training in abuse and neglect prevention, cultural awareness, advocacy services and the code of rights, and health and safety infection control.</p> <p>Tool box education sessions were re-introduced in September 2016 covering topics such as falls prevention, and pressure injury. Where staff have attended education a record of attendance is kept on their individual files.</p> <p>Staff are required to complete competencies in manual handling, hand washing, use of the hoist, emergency management and medication. Not all staff have completed the required competencies (11 of 22 staff have not completed manual handling, 16 of 22 have not completed hand</p>	<p>i) There was no documented education planner for 2016, and no documented education plan for 2017.</p> <p>ii) Not all staff currently employed have received training in abuse and neglect prevention, cultural awareness, advocacy services and the code of rights, management of wounds and pressure injuries, and infection control.</p> <p>iii) Not all staff have completed the required competencies.</p> <p>iv) The Infection control coordinator has not completed education in relation to infection control.</p> <p>v) Not all staff who work in the kitchen have completed food safety training.</p> <p>vi) Three of three staff recently</p>	<p>i-ii) Ensure that the annual education planner is fully implemented and that education and training is provided to meet the requirements of the health and disability sector standards and the aged related residential care agreement.</p> <p>iii) Ensure that all staff complete the required competencies.</p> <p>iv) Ensure the IC Coordinator completes the required education in relation to IC.</p> <p>v) Ensure that all</p>

		<p>washing, 11 of 22 have not completed the use of a hoist and 8 of 22 staff have not completed emergency management).</p> <p>The IC coordinators have not completed education in relation to IC in the past 12 months.</p> <p>Caregivers who work in the kitchen on an afternoon shift have not completed food safety training.</p> <p>In the staff files sampled not all staff have had an annual performance review or a review completed six weeks after employment.</p>	<p>employed have not had a six-week performance review completed and three of three staff due for an annual review had not had these completed.</p> <p>vii) The nurse manager/registered nurse has had an annual review completed on the registered nurse component of the role, but no review has been completed on the management and leadership aspects of the role.</p>	<p>staff who work in the kitchen have completed food safety training.</p> <p>vi) Ensure that performance reviews are completed within the required timeframes for all staff.</p> <p>vii) Ensure that all aspects of the nurse manager/registered nurse role is appraised at least annually.</p> <p>90 days</p>
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA</p> <p>Moderate</p>	<p>The roster is published in advance and there is a registered nurse rostered on each shift. The care staff interviewed advised that staff are replaced where possible if staff are off sick. The nurse manager/registered nurse is the only RN on the am shift four days per week. The nurse manager/registered nurse is required to complete all other duties related to facility management one day per week (education, restraint coordinator, HR, quality management, administration and reception - except billing). The nurse manager/registered nurse reports that the time spent working as an RN on the floor makes it difficult to complete the managerial responsibilities and tasks required.</p> <p>There is one registered nurse and one caregiver</p>	<p>i) There are insufficient hours allocated to complete the operational management and leadership requirements of the role.</p> <p>ii) There are insufficient care staff allocated to resident cares on an afternoon shift between 1530 and 1830.</p>	<p>i) Ensure that there are sufficient hours allocated to complete the operational requirements of the facility management role.</p> <p>ii) Ensure there are sufficient staff rostered on at all times to meet the needs of the residents.</p>

		rostered on for resident cares between 1500 and 1830. A second afternoon caregiver is required to work in the kitchen from 1530 to 1830 and is not available for resident cares during this time. On the day of audit seven of the nine hospital residents required two person cares. The care staff interviewed report that when the RN is completing the medication round, having only one caregiver to attend to the resident's requests for assistance, over this period, can be difficult. The residents interviewed report there can be delays in call bells being answered during this time.		30 days
<p>Criterion 1.2.9.7</p> <p>Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.</p>	PA Low	<p>Current residents' files are stored in an unlocked metal cabinet in the nurse manager/registered nurse's office. There are multiple folders (eg, wound care, doctor's rounds, letters from the hospital, billing information) and monitoring forms on open shelves and benches in this office. The office was not locked and can be accessed from the main corridor by the front door, and/or through an adjacent resident bedroom door. This office has a large open bench area which could not be locked.</p> <p>Archived information is stored in a metal filing cabinet adjacent to the dining room. On the first day of audit this cabinet was not locked however it was locked on the second day of audit. The shower list with resident names was on a noticeboard that could be seen by other residents and the public</p>	<p>i) Information of a private or personal nature is not stored securely in the nurse manager/registered nurse's office.</p> <p>ii) The archived resident information was not securely stored.</p> <p>iii) Names of residents on a shower list were displayed on a noticeboard that could be read by the public and/or other residents.</p>	<p>i-ii) Ensure all resident information of a private or personal nature is maintained in a secure manner.</p> <p>iii) Ensure that resident information is not visible by other residents or the public</p> <p>60 days</p>
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment,</p>	PA Low	The admission agreement was sighted in five of five files. Not all contractual requirements were	The admission agreement did not include all the contractual clauses around termination of	Ensure the admission agreement aligns

and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.		included in the admission agreement.	the agreement and timeframe for refund of overpayments.	with the DHB contractual requirements.  90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Medications are delivered in blister packs and all medications are stored safely. The RN checks the medications against the medication chart and signs the blister pack. There is an antibiotic stock available to the GP for prescribing afterhours if required. All medications were within the expiry dates except some antibiotics in stock.	Three bottles of antibiotic stock had expired.	Ensure all medications held are within the expiry dates.  60 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	The policy requires annual competencies and annual medication training, however not all staff administering medications have completed the annual requirement. An RN was observed to administer medications safely and as per medicine administration protocol.	(i) The nurse manager/registered nurse is responsible for assessing staff for medication competency but has not completed the annual competency. Two RNs and three caregivers also have not completed the annual medication competency. (ii) There is no documented evidence of clinical staff attending annual medication education.	(i) Ensure medication competencies are completed annually. (ii) Ensure clinical staff attend medication education annually.  30 days
Criterion 1.3.3.3 Each stage of service	PA Low	All files reviewed had an initial assessment, InterRAI assessments and long-term lifestyle plan	The InterRAI assessment tool had not been used for the six-	Ensure the InterRAI assessment tool is

<p>provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>developed within 21 days of admission. Lifestyle plans had been evaluated six monthly however the InterRAI assessment tool has not been utilised for two resident six monthly reviews.</p>	<p>monthly review of two residents (one rest home and one hospital level of care).</p>	<p>used as part of the six-monthly review of the resident lifestyle plan.</p> <p>90 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Lifestyle plans are developed in consultation with the resident/relative. Information used from assessments, GP medical notes and discharge summaries is used to describe the required support/interventions to meet the resident needs. Four of five lifestyle plans (one hospital and three rest home) did not reflect the resident's current interventions and needs/supports.</p>	<p>Four of five lifestyle plans (one hospital and three rest home) did not reflect the resident current interventions and needs/supports for the following; (i) One hospital resident with behaviours as reported in progress notes. (ii) Changes in behaviours and sleep pattern for one rest home resident with cognitive decline. (iii) Early warning signs and symptoms of declining mental health for one rest home resident as per the discharge summary. (iv) No pain management plan for one rest home resident with identified pain. There were no documented interventions for the same resident with an ongoing peripheral oedema.</p> <p>Two hospital residents who identify as Māori did not have specific interventions documented in their care plan to meet their cultural and spiritual needs. One resident who identified with a different culture, had no specific interventions documented in their care plan to</p>	<p>Ensure lifestyle plans reflect the resident's current needs/supports to meet the resident goals. Ensure that residents who identify with another culture have their cultural and spiritual needs documented in their care plan. Ensure that residents who identify as Māori have their cultural and spiritual needs documented in their care.</p> <p>60 days</p>

			meet their cultural and spiritual needs.	
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Monitoring occurs for weight, vital signs, blood glucose, pain, wounds, continence and two hourly positioning. There was no monitoring in place for a resident with weight loss and three residents post-unwitnessed falls.</p>	<p>(i) There were no documented interventions for one rest home resident with a 3.5kg weight loss in one month and (ii) neurological observations had not been completed for three residents with unwitnessed falls.</p>	<p>(i) Ensure interventions are implemented for residents with weight loss and (ii) complete neurological observations for unwitnessed falls.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>Long-term lifestyle plans had been reviewed at least six monthly. Acute care plans are used to document short-term needs and guide staff in the delivery of care, however these had not been reviewed within a timely manner.</p>	<p>Two of two acute care plans had not been evaluated as either resolved or updated as an ongoing problem.</p>	<p>Ensure acute care plans are evaluated within a timely manner.</p> <p>90 days</p>
<p>Criterion 1.4.1.1</p> <p>Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial</p>	<p>PA Moderate</p>	<p>Chemical supplies are kept in a locked cupboard. Information on chemical use and products were available for staff. Shortfalls were identified around chemical safety on the day of audit.</p>	<p>(i) Several chemical bottles were sighted in showers and toilets in the facility and the sluice room was found to be unlocked on several occasions throughout the audit. (ii) Two bottles of chemicals did not have manufacturer labels.</p>	<p>(i) Ensure chemicals are stored safely. (ii) Ensure all chemical bottles have manufacturer labels.</p> <p>60 days</p>

authority requirements.				
<p>Criterion 1.4.1.6</p> <p>Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.</p>	<p>PA Moderate</p>	<p>Gloves were worn appropriately by staff carrying out their duties. Gloves were available around the facility however not all personal protective equipment was available.</p>	<p>Aprons and visors were not available at the point of use in the sluice room and laundry sluice area.</p>	<p>Ensure personal protective wear is available at the point of use.</p> <p>30 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>Electrical testing of equipment is carried out by an approved contractor. Not all electrical equipment had been electrically tested and tagged. The planned maintenance programme does not include a replacement plan for flooring or replacement of hand basins.</p>	<p>(i) There were two electric beds with badly frayed cables to the hand remote controller. These had been missed during the annual electrical check. One bed was not in use. The maintenance person was called in to cover the cables with a safe covering and notify the electrical contractor. Electric wall heaters in resident rooms had not had an annual electrical check. (ii) The studio hallway carpet has damaged areas caused by carpet eating bugs, which has been treated. The dining room vinyl is split in several areas posing an infection control risk. (iii) There is one cracked hand basin in a communal toilet and a damaged hand basin in the staff toilet.</p>	<p>(i) Ensure all resident and environmental equipment has an annual electrical safety check. (ii) Ensure flooring meets hygiene and safety standards. (iii) Ensure hand washing stations meet infection control standards.</p> <p>60 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive</p>	<p>PA Low</p>	<p>The registered nurses at Brylyn are required to hold a current first aid certificate. Two of six</p>	<p>The facility is not covered by a minimum of one staff member on</p>	<p>Ensure there is a minimum of one</p>

appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.		registered nurses and the nurse manager/registered nurse do not have a current first aid certificate. There are no other staff with a first aid certificate rostered on at the time these RNs are working. The activities coordinator who accompanies residents on outings has a current first aid certificate. Emergency management competencies are required to be completed (link 1.2.7.5).	each shift who holds a current first aid certificate.	staff with a current first aid/CPR certificate available at all times.  180 days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Moderate	The approved fire evacuation scheme was sighted. Trial evacuations were documented for February 2016 and February 2017. The nurse manager/registered nurse interviewed advised that 6 monthly fire evacuation drills had been held, however the documentation to evidence this in August 2016 could not be located. The fire service were contacted and had not received a copy of the evacuation report.	Six monthly trail evacuations could not be evidenced.	Ensure that six monthly trail evacuations are consistently held and the required documentation is completed.  60 days
Criterion 1.4.7.5 An appropriate 'call system' is available to summon assistance when required.	PA Moderate	The service has a call bell system in place. Call points are available in all communal areas, bathrooms and bedrooms. Some resident bedrooms had call switches on the wall by the bed, which were activated by pushing the switch down. Not all residents could reach and activate the call point switches and these residents had not all been supplied with a call bell cord. One resident interviewed advised that she was unable to push the button on the call bell. The resident advised that staff frequently check on her. The nurse manager/registered nurse advised an alternative call bell had been ordered for this resident on the day of audit, and replacement call bell cords had also been ordered.	i) Eight of thirty-two resident bedrooms had call points in the wall with no cord attached and the residents could not reach the switch easily from the bed.  ii) One resident interviewed advised that they could not use the call bell provided because of their health issues.	i-ii) Ensure that all residents have access to a call bell they can operate.  30 days

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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.