# Bryant House Limited - Bryant House

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Bryant House Limited

**Premises audited:** Bryant House

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 14 March 2017 End date: 15 March 2017

**Proposed changes to current services (if any):** None

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

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Bryant House provides residential care for up to 33 residents who have been assessed as requiring rest home and rest home dementia level care. On the first day of audit all 33 beds were occupied. The facility is operated by Bryant House Limited.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

Residents and families were very complementary of the care provided.

Areas requiring improvement from this audit relate to the provision of a designated person skilled in diversional and motivational activities for the dementia unit; residents in the dementia unit not having individualised activity plans, and the infection control and prevention programme which has not been reviewed annually.

## 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. |

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

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

There were no residents who identified as Maori residing in Bryant House on the days of audit.

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

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

The general manager is responsible for the management of complaints and a complaints register is maintained. There has been one investigation and follow-up with the complainant, by the district health board since the previous 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. |

Bryant House Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Bryant House. Systems are in place for monitoring the service, including regular reporting to the owner/general manager.

The facility is managed by the owner/general manager who has a background in management. The general manager is supported by a clinical manager who is a registered nurse. The clinical manager is responsible for oversight of the clinical service in the facility.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and quality meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, staff and resident and family meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks. The health and safety representative has completed an update on the Health and Safety at Work Act (2015) requirements.

Human resources processes are followed. There are policies and procedures on human resources management. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored.

There is a documented rationale for determining staffing levels and skill mix. A registered nurse is rostered on duty during the week. The clinical manager, registered nurse and general manager are on call after hours.

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, legible and relevant residents’ records are maintained using electronic and hard copy files.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The organisation works closely with the local Needs Assessment and Service Coordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents’ needs are assessed on admission within the required timeframes. Registered nurses are on duty eight hours each day in the facility and are supported by care staff and a designated general practitioner. On call arrangements for registered nurse support are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents’ files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme in the rest home provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

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

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised and clean. Residents in the secure unit have access to food at all times. Residents and family members 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. |

All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Single accommodation is provided. Adequate numbers of bathrooms and toilets are available. There are a several lounges, dining areas and alcoves. External areas for sitting and shading is provided. The external area for residents in the dementia unit is secure and inviting.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems, including appropriate monitoring, is undertaken to evaluate the effectiveness of these services.

## 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. |

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were no residents using restraint or enablers during the audit.

## Infection prevention and control

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk. |

The infection prevention and control programme, led by two experienced and appropriately trained infection control coordinators, aims to prevent and manage infections. Specialist infection prevention and control advice can be accessed from the District Health Board.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 43 | 0 | 1 | 1 | 0 | 0 |
| **Criteria** | 0 | 91 | 0 | 1 | 1 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Bryant House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form including for photographs, outings, invasive procedures and collection and sharing of health information.  Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident’s records. Staff demonstrated their understanding by being able to explain situations when this may occur. All resident files reviewed in the secure unit had an appointed enduring power of attorney (EPOA). An upcoming family meeting had a lawyer attending to provide families with information on establishing an EPOA.  Staff were observed to gain consent for day to day care on an ongoing basis. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.  Staff are aware of how to access the Advocacy Service. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available within the facility.  The complaints register showed three complaints were received during 2016 and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed show any required follow up and improvements have been made where possible.  The general manager (GM) is responsible for complaints management and follow up. Staff interviewed understood the complaint process and what actions are required.  The GM reported there has been an investigation by the district health board since the previous audit relating to the care of a resident who is no longer resides at Bryant House. The GM reported the district health board has investigated the complaint and advised the GM they would respond to the complainant and no further action was required by Bryant House. Documentation reviewed showed communication with the family including meetings held at Bryant house. There have been no investigations by the Health and Disability Commissioner, the Ministry of Health, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff and in the monthly newsletter. The Code is displayed in numerous areas around the facility together with information on advocacy services, how to make a complaint and feedback forms. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately and exchanging verbal information. All residents have a private room.  Residents are encouraged to maintain their independence by being assisted to attend community activities and participating in clubs and activities of their choosing or interest. Each plan included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff interviews and training records. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There were no residents in Bryant House who identified as Maori on the days of audit. Staff verified their ability to support any residents who did identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Residents and family/whanau verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident’s personal preferences, required interventions and special needs were included in all care plans reviewed (eg, food preferences and spiritual beliefs). A resident satisfaction questionnaire includes evaluation of how well residents’ cultural needs are met and this supported that individual needs are being met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.  The induction process for staff includes education related to professional boundaries and expected behaviours. Both registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Related ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, community dieticians, services for older people, psychogeriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks, through the Hawke’s Bay District Health Board (HBDHB) to support contemporary good practice.  Other examples of good practice observed during the audit included management of residents with challenging behaviour. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Interpreter services can be accessed via the DHB when required. Staff knew how to do so, although reported this was rarely required due to all residents at present being able to speak English. Processes are in place to communicate with a resident who has a wide range of communication deficits. Evidence supports the effectiveness of these processes. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bryant House is a family owned and operated business. A business plan and a quality and risk management plan were reviewed and includes a mission statement, philosophy, vision, objectives and a strengths, weaknesses, opportunities and threats (SWOT) analysis. An organisational flowchart shows the structure and reporting lines within the organisation. The service philosophy is in an understandable form and was available to residents and their family / representative or other services involved in referring clients to the service.  Bryant House Limited has established systems in place which defined the scope, direction and goals of the organisation as well as the monitoring and reporting processes against these systems.  The clinical manager (CM) and the GM meet on a regular basis to discuss occupancy, staffing and human resources management, environmental and general issues that arise.  One of the owners is the GM who is actively involved in the aged care sector. The GM is supported by an experienced clinical manager (CM) / registered nurse (RN). The CM has been in this role since January 2014 and prior to this appointment was a RN working at Bryant House. The CM is responsible for oversight of clinical care provided to residents. The CM has completed two management and leadership courses since the previous audit. The GM and CM are also supported by an administrator and a quality improvement team consisting of other staff members from within the facility.  Bryant House is certified to provide 33 beds, of which 16 are for rest home level care and 17 for rest home dementia level care. On day one of this audit all beds were occupied. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | In the absence of the GM, the CM and the administrator deputise. When the CM is absent, the RN takes responsibility for clinical overview. The GM, CM and RN confirmed their responsibility and authority for these roles. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management plan guides the quality programme and included goals and objectives. An internal audit programme is in place and audits have been completed as per the schedule. Clinical indicators and quality improvement data was recorded on various registers and forms. Data is being collected, collated and analysed to identify trends. Corrective actions are developed and implemented to improve service delivery following completion of internal audits, surveys, incident/accidents, complaints and any deficits identified at the various meetings. There was good evidence of monitoring to ensure corrective actions have been effective. Interview of the CM and administrator evidenced their sound knowledge relating to quality and risk management.  Meeting schedules and minutes reviewed demonstrated that monthly quality and staff meetings are held. Meeting minutes evidenced reporting of clinical indicators including trends and graphs. The CM also holds weekly meetings with care staff and observation and interviews of staff provided evidence of a comprehensive review of residents and any other matters expressed by staff for discussion. This forum is also used for education with regards to any health event a resident may be experiencing. Resident meetings are held at least three monthly and family meetings six monthly. A two-monthly newsletter is also generated by the administrator and given to residents and sent out to families which gives useful information about what is happening at Bryant House.  Policies and procedures are reviewed and were current and fully implemented. They are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. An interRAI policy includes assessment, planning and evaluation. Staff are updated on new/reviewed policies and this was confirmed during interviews of care staff. Care staff confirmed the policies and procedures provided appropriate guidance for the service delivery.  Actual and potential risks are identified and documented in the hazard register. The hazard register identifies hazards and showed the actions put in place to minimise or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The administrator is the health and safety coordinator, is responsible for hazards and demonstrated good knowledge. Staff confirmed they understood and implemented documented hazard identification processes. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. The clinical manager reviews and collates these. The original is kept in the residents’ files. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.  There is an open disclosure policy. Residents’ files evidenced communication with families following adverse events involving the resident, or any change in the resident’s condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative’s condition.  Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The GM advised there have been no essential notifications (Section 31) made to the Ministry of Health since the previous audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.  The education programmes for 2016 and 2017 were reviewed and are the responsibility of the CM. There was evidence of in-service education provided. Staff attend study days at another local aged care facility and the CM and RN also attend external education provided by, but not limited to, the local DHB. Individual records of education are maintained as are competency assessments. Staff files evidenced education records and competency assessments including medication management. The CN and RN both have current interRAI competencies.  A New Zealand Qualification Authority education programme is provided for staff and all staff have completed or are currently completing the dementia modules. The CM is the assessor for the service. All staff have completed at least eight hours of in-service education.  An orientation/induction programme is available and all 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 two weeks to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.  Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.  Care staff confirmed they have completed an orientation, including competency assessments. Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. The CM is responsible for managing the rosters and considers dependency levels of residents both in the rest home and dementia unit. The minimum number of staff is provided during the night shift and consists of two caregivers, one in the rest home and the other in the dementia unit. During the week, there is a RN on the floor, plus the clinical manager. The GM is on call after hours for any non-clinical issues and the CM and the RN are rostered on week about for any clinical concerns. Care staff interviewed reported there was adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident’s name and National Health Index (NHI) number are hand written onto each document as a unique identifier on all residents’ information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the date, time, signature and designation of the person making the entry identifiable. Evidence verified any errors in files were managed as per documentation policy.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with manager. They are also provided with written information about the service and the admission process.  Specialist referral for residents in the secure unit was sighted, with the EPOA having consented to admission.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB’s ‘yellow envelope’ system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and progress notes is provided for the ongoing management of the resident. All referrals are documented in the progress notes. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management was observed 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. Medication administration records are generated by the pharmacy, and signed each time medication administered is in line with that prescribed. All administration records reviewed at audit were correct. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.  There were no controlled drugs in use at the time of audit. Controlled drugs however are stored securely in accordance with requirements. Controlled drugs were evidenced to be checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.  There were no residents self-administering medications at the time of audit.  Medication errors are reported to the manager and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are used, are current and complied with guidelines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident’s nutritional needs, was available.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the clinical manager. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of two trained interRAI assessors on site. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. In particular, the needs identified by the interRAI assessments are reflected in the care plans reviewed.  Care plans of residents in the secure unit included behaviour management plans that included triggers and intervention for behaviours.  Care plans evidence service integration with progress notes and activities notes. Medical and allied health professional’s notations are clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a satisfactory standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate | The activities programme in the rest home is provided by an activity co-ordinator, who although had completed some of the diversional therapy training many years ago, is not qualified. A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated as residents needs change and as part of the formal six monthly care plan review.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities programme is discussed at the minuted residents’ meetings and resident/family meetings and indicated residents’ and family input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme enjoyable.  On admission to the secure unit, the RN undertakes a comprehensive assessment of the resident. This includes a social assessment and history to ascertain residents’ interests, abilities and social requirements. There is no designated person skilled in assessment, implementation and evaluation of diversional and motivational activities involved in the activities in the secure unit. Activities are provided by care staff at times when residents are most physically active and/or restless. Activities are specific to the needs and abilities of the people living there, and includes entertainment from visiting community groups and outings in the van. There is no evidence activities are planned based on residents strengths, skills and interests. Interviews with families verify satisfaction with the activities provided by care staff. Residents were observed to be settled. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents’ needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and evaluated as clinically indicated (daily, weekly or fortnightly) and according to the degree of risk noted during the assessment process were sighted. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to older persons’ mental health services. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current.  There was protective clothing and equipment in the sluice room and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a good understanding of processes relating to the management of waste and hazardous substances. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness was displayed. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. Residents confirmed they can move freely around the facility and that the accommodation meets their needs.  There is a proactive and reactive maintenance programme and the buildings, plant and equipment was maintained to an adequate standard. Maintenance is undertaken by the GM and external companies are contracted if required. The testing and tagging of electrical equipment and calibration of bio-medical equipment was current.  There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The gardens are maintained by a gardener on a weekly basis. The environment was conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. The external area for the dementia unit was secure and safe for residents to wander freely.  Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There is a mix of bedrooms with ensuites consisting of a toilet and wash hand basin, some bedrooms that share an ensuite, and some bedrooms have a wash hand basin. There are adequate numbers of additional bathrooms and toilets throughout the facility. Residents and families reported that there are sufficient toilets and they are easy to access.  Appropriately secured and approved handrails are provided and other equipment was available to promote residents’ independence. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All bedrooms provide single accommodation and there is a mix of different sizes. Adequate personal space is provided for residents and staff to move safely. Residents and families spoke positively about their or their relative’s accommodation. Rooms are personalised with furnishings, photos, and other personal adornments.  There is adequate room in the facility to store mobility aids such as mobility scooters, wheel chairs and walkers. |
| 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 | Areas are provided for residents to frequent for activities, dining, relaxing and for privacy. Residents, families and staff confirmed and observation evidenced these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. |
| 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 | All laundry is washed on site. Residents and families reported the laundry is managed well and resident’s clothes are returned in a timely manner.  Bryant House is cleaned to an adequate standard. Residents and families and the 2016 satisfaction surveys confirmed this. Cleaning is the responsibility of the care staff and they have received appropriate education. Chemicals are stored securely. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved fire evacuation plan. There is an evacuation policy on emergency and security situations that covers the service groups within the facility. A fire drill takes place six-monthly. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the days of audit and all equipment had been checked within required timeframes.  There is always at least one staff member on duty with a current first aid certificate.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs. Back up lighting is available should there be a power outage. Emergency procedure flip charts are situated throughout the facility.  There are call bells to alert staff. Residents and families reported staff respond promptly to call bells.  Contractors must sign in and out of the facility. They are also made aware of any hazards on site. The external doors are locked in the evenings and there are security lights situated around the building. There is key pad entry to the dementia unit. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heat pumps and electric heaters provide heating. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | PA Low | The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the DHB infection control nurse. However, there is no evidence to support the programme has been reviewed annually.  The Registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. The IPC coordinator is mentored and supported by the Clinical manager. Infection control matters including surveillance results, are reported monthly to the managers at staff meetings and tabled at the quality meeting. The quality meeting includes the general manager, IPC coordinator, the health and safety officer, and representatives from activities, food services and household management  The two monthly newsletter requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control coordinator and Clinical manager have appropriate skills, knowledge and qualifications for the role. The Clinical manager was previously in this role for four years. Both IPC coordinator and the Clinical manager have attended relevant IPC study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available and expert advice from the community laboratory is available if additional support/information is required. The IPC coordinator and Clinical manager have access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The IPC coordinator and supporting Clinical manager confirmed the availability of resources to support the programme and any outbreak of an infection. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2016 and include appropriate referencing.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by the IPC coordinator and supporting Clinical manager. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was an increase in urinary infections.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented on the infection reporting form and clinical records. The IPC coordinator and supporting Clinical manager review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager and at the quality meeting. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There were no residents using restraint or enablers during the audit. The policies and procedures have good definitions of restraints and enablers. The CM is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation. Staff demonstrated sound knowledge about restraint processes including the difference between restraints and enablers. The GM and CM advised restraint is not used at Bryant House. The restraint coordinator and staff described how they manage challenging behaviour and the use of equipment, such as sensor mats. |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | Observation and interviews evidenced activities in the secure unit are carried out daily by the care staff, based on the care staffs’ day to day assessment of what each resident enjoys doing. Evidence verified activities provided are not based on any planned approach or in line with residents past interests, strengths or skills There is no designated person skilled in assessment, implementation and evaluation of diversional and motivational activities in the secure unit. Six of seven files reviewed had no individualised activity plan in place to promote residents’ strengths, skills and interest. | Activities provided in the secure unit are not provided by a designated person skilled in providing activities for residents in the secure unit. Activities are unplanned and are not based on the residents’ life, past interests and past routines. | There is a designated person skilled in assessment, implementation and evaluation of diversional and motivational activities in the secure unit. Activities are planned based on residents’ skills, strengths and interests.  90 days |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | Documentation, interviews and observation verify there is a clearly documented infection control programme. The infection control policies have been reviewed within the last year, education, audits, surveillance and training is ongoing however there is no evidence to verify the IPC programme has been reviewed annually. | The infection control programme has not been reviewed annually. | The infection prevention and control programme is reviewed annually.  180 days |

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

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

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

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

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End of the report.