# Annie Brydon Complex Limited - Te Mahana

## 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:** Annie Brydon Complex Limited

**Premises audited:** Te Mahana Resthome

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

**Dates of audit:** Start date: 11 July 2017 End date: 13 July 2017

**Proposed changes to current services (if any):** HealthCERT has requested that specific reference to the reconfiguration of services at both Annie Brydon Rest home and Hospital and Te Mahana Rest Home be included in this audit. Three apartments at Annie Brydon Rest Home and Hospital changed from single accommodation to double accommodation for married couples. The rooms are under an occupational right agreement and are certified for rest home level care. This will increase the total capacity from 68 beds to 71. Two bedrooms with full ensuites and a lounge have been built on to the existing building at Te Mahana Rest Home increasing total accommodation to 22 beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 89

# 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

Annie Brydon Rest Home and Hospital and Te Mahana Rest Home provide residential care for up to 90 residents at two facilities. Annie Brydon Rest home and Hospital provides residential accommodation for up to 68 residents who require hospital and rest home level care. Occupancy on day one was 68. Te Mahana Rest Home provides rest home care for up to 22 rest home residents and occupancy was 21. Both facilities are operated by Annie Brydon Complex 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, a general practitioner and allied health professionals.

Continuous improvement ratings have been awarded relating to the reduction in restraint use, residents and families accessing the community, children visiting the facility and pressure injuries. There are no areas requiring improvement from this audit.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

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.

Resident who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and was 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.

Complaint registers are maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Annie Brydon Complex Limited is the governing body and is responsible for the service provided at Annie Brydon Rest Home and Hospital in Hawera and at Te Mahana Rest Home in Patea. The documented scope, direction, goals, values, and a mission statement were reviewed. Systems are in place for monitoring the services provided including regular reporting by the managers to the governing body.

One of the directors is the facility manager at Annie Brydon Rest Home and Hospital and is supported by a clinical nurse manager who is a registered nurse. Oversight of the clinical services provided at both sites is provided by the clinical nurse manager from Annie Brydon Rest Home and Hospital. A registered nurse from the local medical centre also provides support to the facility manager at Te Mahana Rest Home and is responsible for the clinical service.

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 meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address issues that require improvement. Quality, health and safety, various staff and resident meetings are held on a regular basis.

The hazard registers evidenced review and updating of risks and the addition of new risks. The health and safety representative for both sites has completed an update on the Health and Safety at Work Act (2015) requirements. There are policies and procedures on human resources management. Human resources processes are followed. Staff have the required qualifications. In-service education programmes are provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are rostered on duty at all times at Annie Brydon Rest Home and Hospital. The clinical nurse manager and managers at both sites 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 in using an integrated hard copy file.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to both facilities 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 by the multidisciplinary team on admission and within the required timeframes. Shift handovers 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 activities programme, 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 kitchens were well organised, clean and met food safety standards. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

A current building warrant of fitness was displayed at both facilities. All building and plant complies with legislation. Preventative and reactive maintenance programmes include equipment and electrical checks.

Apart from one bedroom at Annie Brydon Rest Home and Hospital, single accommodation is provided with a mix of shared and single full ensuites. All bedrooms at Te Mahana Rest Home are single and the two new rooms have their own full ensuites. Adequate numbers of additional bathrooms and toilets are available. There are several lounges, dining areas and alcoves. External areas for sitting and shading is provided at both sites.

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 was safely stored. All laundry is washed on the site. Cleaning and laundry systems are audited for effectiveness.

The provider has requested three apartments at Annie Brydon Rest Home and Hospital be changed from single accommodation to double accommodation for married couples. Two bedrooms with ensuites and a lounge have been built onto the existing building at Te Mahana Rest Home. These rooms are suitable for their intended purpose.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | All standards applicable to this service fully attained with some standards exceeded. |

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There was a resident using restraint at Te Mahana Rest Home and no residents using enablers during the audit. Appropriate documentation including current restraint registers were in place. There are currently no residents using restraint at Annie Brydon Rest Home and Hospital.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection prevention and control programme, led by an experienced and appropriately trained infection control officer, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board. The programme is reviewed annually.

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 and 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** | 1 | 49 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 4 | 97 | 0 | 0 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 | Annie Brydon Rest Home and Hospital (Annie Brydon) and Te Mahana Rest Home (Te Mahana) have developed policies, procedures and processes to meet their obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed at both facilities 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 understood 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 consent for photographs, outings, names on doors and the 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 record. Staff demonstrated their understanding by being able to explain situations when this may occur.  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. Brochures related to the Advocacy Service were also displayed in the facilities. 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 and examples of their involvement were discussed.  A resident advocate regularly visits at both facilities. An interview with the advocate at Te Mahana, verified residents were well informed of their rights, the advocacy service, and were aware the advocate will deal with concerns they may have and are not comfortable to deal with. Any concerns residents or family members have are dealt with promptly by the facility manager (FM), however concerns expressed are very few. |
| 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’ family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.  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 (refer 1.3.7.1). The ability for residents to maintain links with family and community has been enhanced at Annie Brydon and this is recognised as an area of continuous improvement.  The facility has unrestricted visiting hours and encourages visits from residents’ family 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 and families on admission and there is complaints information and forms available throughout the facilities.  The complaint registers showed one complaint at Annie Brydon Rest Home and Hospital (Annie Brydon) and none at Te Mahana Rest Home (Te Mahana) have been received since the previous audit. Actions taken, through to an agreed resolution, was documented and completed within the timeframes specified in the Code. The action plan reviewed showed any required follow-up and improvements have been made where possible.  The facility managers and the quality manager are responsible for complaints management and follow-up. Staff interviewed confirmed a good understanding of the complaint process and what actions are required.  The facility managers (FMs) and the quality manager (QM) reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported 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 by ongoing discussion with the facilities resident advocates. Information on the Code, the advocacy service, how to make a complaint and feedback forms were displayed in the entrance foyers at both facilities. |
| 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, exchanging verbal information and enabling residents’ privacy for discussions. All residents have a single room, with the exception of one room at Annie Brydon which is shared with another person with their consent.  Residents are encouraged to maintain their independence by involvement in community activities, participation in clubs of their choosing and the provision of opportunities to maximise individuals choice (refer 1.1.12 and 1.3.7.1). 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 by staff and training. |
| 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 | Staff support a number of residents in both facilities who 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 cultural assessment for all residents who identify as Maori that includes a holistic model within Maoridom (Whare Tapa Wha). Current access to resources includes the contact details of local cultural advisers and the community. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Interview with a resident who identified as Maori verified that staff acknowledge and respected individual cultural needs. |
| 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 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. Residents satisfaction questionnaires 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 (GP) for Annie Brydon and the practice manager for the practice that serviced Te Mahana, 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. All registered nurses (RN’s) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their employment agreement. 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 access to online training, evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, district nurses, dieticians, services for older people, mental health services for older persons, and education of staff. The GP and facility manager (FM) at Te Mahana 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 on-line learning with guidance from the clinical nurse manager (CNM) to support contemporary good practice.  Other examples of good practice observed during the audit included the processes in place to manage the limitations imposed by the services location. |
| 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 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 are able to be accessed via the regions interpreters when required. Staff knew how to do so, although reported this was rarely required due to all present residents being able to speak English, staff able to provide interpretation as and when needed, the use of family members and communication cards for a resident who is unable to speak.  Staff were observed communicating effectively with residents and family. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Annie Brydon complex Limited is the governing body and is responsible for the service at both sites. Business plans were reviewed that include a mission statement, vision, purpose and objectives with six key areas.  Annie Brydon is managed by a facility manager who is one of the directors, is experienced and has been in this position for two years. The management of clinical services is the responsibility of the clinical nurse manager (CNM) who has been in their role for two years. Prior to this appointment, the CNM was employed as a team leader/RN at Annie Brydon. The annual practising certificate for the clinical nurse manager is current. There was evidence on the facility manager’s and clinical nurse manager’s files of appropriate ongoing education.  Te Mahana is managed by a facility manager who was appointed to this position in December 2006. The manager has experience in the aged care sector. The CNM from Annie Brydon and the quality manager for the group also provide support for the manager at Te Mahana. The CNM visits once a week and an RN from the local medical centre is employed approximately eight hours per week to provide RN input. The RN stated they visit the facility every day and know the residents well. The medical centre is across the road from Te Mahana and the RN stated they are available should staff require any advice from the RNs.  The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.  Annie Brydon occupancy on the first day of this audit was 56 rest home and 12 hospital residents including one resident who is under the age of 65 years. Thirty rooms have been approved for dual purpose accommodation and 14 smaller rooms are rest home level care. Twenty-four beds are under an occupational right agreement  The service provider has funding contracts with the district health board (DHB) to provide aged related residential care, long term support – chronic health conditions, residential respite - rehabilitation and support services, and short term residential care services for people in contracted residential facilities.  Te Mahana occupancy was 21 rest home level residents. The service provider has contracts with the DHB to provide residential respite services-rehabilitation and support services and age related residential care services. |
| 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 | At Annie Brydon, in the absence of the facility manager, the clinical nurse manager deputises. When the CNM is absent, a team leader/RN takes responsibility for clinical overview. The quality manager provides support. At Te Mahana when the FM is absent, the CNM from Annie Brydon deputises. The FMs and the CNM 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 improvement and risk management plan guides the quality programme and includes goals and objectives. Internal audit programmes are in place and internal audits completed for 2016 and 2017 were reviewed. Hazard registers identify health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures. The CNM is the health and safety coordinator for both sites and is responsible for hazards. The CNM demonstrated a sound understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.  Annie Brydon has quality and risk meetings that include RNs, ENs, health and safety, restraint and infection prevention and control. General staff meetings are held three-monthly, with a comprehensive newsletter that includes on-going education provided monthly for staff. Resident and support service meetings are held two monthly.  Monthly staff meetings are held at Te Mahana and the FM attends the quality meetings at Annie Brydon and provides a monthly report to the governing body.  Meeting minutes including quality data is available in the nurses’ stations for staff to read and sign off. Meeting minutes and staff newsletters reviewed evidenced reporting of completed internal audits, quality data, including clinical indicators which are graphed. The quality manager is experienced in quality and risk management processes and is responsible for ensuring the organisation’s quality and risk management systems are maintained at both facilities.  Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed and reported. Quality improvement data included adverse event forms, internal audits, meeting minutes, satisfaction surveys and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed.  Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. The ‘Lifestyle Care Plan Policy’ includes interRAI requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed they are advised of updated policies and that they provide appropriate guidance for the service delivery. |
| 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 including a neurological observation form and falls risk assessments completed following accidents/incidents as appropriate. These are collated by the facility manager and quality manager. The originals are 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. The satisfaction surveys confirmed this.  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. |
| 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 in relation to human resources management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientation. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.  The clinical nurse manager (CNM) at Annie Brydon and the manager at Te Mahana are responsible for management of the in-service education programme at each facility.  In-service education is provided for staff using several approaches, including monthly sessions, on-line learning, ‘tool box’ talks at handover, specific topics relating to resident’s health status, monthly staff newsletters and staff meetings. Staff from Te Mahana also attend education sessions held at Annie Brydon. The local DHB provides education and staff have also attended other external education. Individual records of education, including competencies, are held on staff files and electronically. Attendance records are maintained. Four RNs are interRAI trained and have current competencies.  The CNM advised a New Zealand Qualification Authority education programme will shortly be reintroduced and available for staff to complete.  A comprehensive 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 to three months 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 were current. Annual practising certificates were current for all staff and contractors who require them to practice.  Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the 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 FMs and CSM reported they review the rosters continuously and consider dependency levels of residents and the physical environment, including the ORA units which form part of the foot print within the facility. The minimum number of staff at Annie Brydon is provided during the night shift and consists of one RN and two caregivers. The FM and CNM are on call after hours.  At Te Mahana there is one caregiver on duty during the night and the facility manager and RN are on call.  Care staff interviewed reported there is 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, date of birth and National Health Index (NHI) number are used as the 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 name and designation of the person making the entry identifiable.  Archived records are held securely at each site and are readily retrievable using a cataloguing system. |
| 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 the FM and RN at Te Mahana or the CNM at Annie Brydon. They are also provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.  Family members and residents 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 a transfer form 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, care plan and recent progress notes is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed a planned, co-ordinated transition. Family of the resident reported being kept well informed during the transfer of their relative. |
| 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 day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facilities in a pre-packaged format from a contracted pharmacy. These medications are checked against the prescription, by an RN at Annie Brydon, and a medication competent nurse at Te Mahana. All medications sighted were within current use by dates. Clinical pharmacist input is provided at both facilities on request.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. There were no controlled drugs at Te Mahana at the time of audit.  The records of temperatures for the medicine fridges and the medication rooms 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 reviews were consistently recorded on the medicine chart.  There were three residents at Annie Brydon who self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. Te Mahana had no residents who were self-administering medications at the time of audit.  Medication errors are reported to the RN at Te Mahana and CNM at Annie Brydon, and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive organisational analysis of any medication errors, and compliance with this process was verified.  Standing orders are only used at Annie Brydon, were current and comply 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 in both facilities is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in October 2016. 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 as part of the plan. The cooks have both 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. Special equipment, to meet resident’s nutritional needs, is 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. There was sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. |
| 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 FM and the CNM. 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 and nutritional screening 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 trained interRAI assessor at Te Mahana and one of three interRAI assessors at Annie Brydon. |
| 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 interRAI assessments are reflected in the care plans reviewed.  Care plans evidence service integration with progress notes, activities notes, medical and allied health professional’s notations clearly written, informative and relevant. Any change in care required is 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 services commitment to ‘zero tolerance of pressure injuries’ is recognised as an area of continuous improvement. The GP and FM interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. 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. | FA | The activities programme at Annie Brydon is provided by two activities officers, and at Te Mahana by the staff and visiting community groups.  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. Examples include lunch outings at a local club, attendance at the community group meetings and attendance at the local monthly dances.  An initiative by the activities officers at Annie Brydon to involve the women’s club, local kindergarten and the school in activities at Annie Brydon is an area of continuous improvement.  Residents of Te Mahana continue to participate in many of the activities offered in the community that they have always been part of, for example, the Country Women’s Institute, old folks group, visits from Kindergarten and local school. A local volunteer group supports the community and also takes residents of Te Mahana to appointments in other areas (eg, Hawera, New Plymouth), if required. The FM generally enables the residents to accompany her when she goes out.  The activities programme is discussed at the minuted residents’ meetings and indicated residents’ input is sought and responded to. Residents and family meetings at Te Mahana are monthly and run by the residents’ advocate. Residents’ meetings at Annie Brydon are bimonthly and run by the activities officers. Interviews, meeting minutes and satisfaction surveys verified resident and family satisfaction with the programme. |
| 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. Short term care plans were consistently reviewed and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the 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 main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, RN or CNM sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files. 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. Safety data sheets were sighted throughout the facilities and are accessible for staff. Hazard registers are current.  There was protective clothing and equipment in the sluice rooms and laundries that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound 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 | Current building warrants of fitness are displayed at both sites. There are appropriate systems in place to ensure the residents’ physical environment and facilities are fit for their purpose. Annie Brydon is spacious and passage-ways are wide. Te Mahana has passage ways that allow residents to pass safely. Residents confirmed they can move freely around both facilities and that the accommodation meets their needs.  At Te Mahana, two bedrooms, each with a full ensuite and a lounge, have been built onto the existing facility. A certificate of public use was sighted for the extension. The rooms are suitable for rest home level care.  At Annie Brydon, the provider is wanting to change apartments one, nine and 12, from single to double accommodation for married couples. HealthCERT has required a call bell system be available for two residents and privacy be provided. Call bells have been installed for use by both residents who will occupy the rooms. The provider has a portable screen to provide privacy if required. Each unit has a separate lounge that can also be utilised should one or other of the occupants require privacy. The apartments are suitable for double accommodation.  There are proactive and reactive maintenance programmes and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by maintenance people. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current.  There are external areas available that are maintained to an adequate standard and are appropriate to the resident groups and setting. The environments are conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.  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 | At Annie Brydon, there is a mix of full ensuites or shared full ensuites. At Te Mahana, the two new bedrooms have large full ensuites. 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 is 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 | There is a mix of different sized rooms at both sites. The two new bedrooms at Te Mahana are very spacious. There is adequate personal space provided for residents and staff to move safely around in all the bedrooms. 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 facilities to store mobility aids such as mobility scooters, wheelchairs 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 | At Annie Brydon, numerous areas are provided for residents to frequent for activities, dining, relaxing and for privacy. At Te Mahana there is a main dining room and lounge and a new lounge built on to the exiting building for residents to enjoy. 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 at both the facilities. Residents and families reported the laundry is managed well and residents’ clothes are returned in a timely manner.  Both facilities are cleaned to a high standard. There are dedicated cleaners on site who have received appropriate education. The cleaners, laundry person and care staff demonstrated a sound knowledge of processes. Residents and families stated both facilities are kept clean. The satisfaction surveys confirmed this. 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 | A letter from the NZ Fire Service dated 17 July 2013 confirmed the fire evacuation scheme is approved for Annie Brydon. A letter from the NZ Fire Service dated 17 May 2017 states that Te Mahana’s evacuation scheme was approved on the 21 July 1994 and remains approved. A fire drill takes place six-monthly at both sites. There is an evacuation policy on emergency and security situations that covers all service groups at the facilities. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted and all equipment has 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.  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 facilities. The external doors are locked in the early evening. |
| 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. Heating at both sites is provided by gas heating that is ducked through the ceilings. 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. | FA | 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 infection control officer (ICO) and IPC nurse at the DHB. The IPC programme and manual are reviewed annually.  The CNM is the designated ICO, whose role and responsibilities are defined in a job description, and extends to cover both facilities. Infection control matters, including surveillance results, are reported monthly to the facility managers, quality manager and general manager and tabled at the quality meeting. This committee includes the general manager/facility manager, ICO, the health and safety officer, and representatives from food services and household management  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these 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 ICO has appropriate skills, knowledge and qualifications for the role, and has been in this role for 18 months. She has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available. The nurse has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICO 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 IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were last reviewed in 2016 and included 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 IPC 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 IPC 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 suitably qualified registered nurses, and the ICO. 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 respiratory 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 and management is documented in the residents’ clinical records and on infection reporting form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The ICO reviews all reported infections. Monthly surveillance data is collated, recorded in the resident management system and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via team meetings, quality meetings, staff meetings and at resident handovers as confirmed in meeting minutes sighted and interviews with staff.  Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality, staff, team and management meetings. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | CI | The service demonstrated that the use of restraint is actively minimised. There was one resident using a restraint at Te Mahana and no residents using an enabler. The restraint coordinator is the CNM for both facilities and demonstrated good knowledge relating to restraint minimisation. The policies and procedures have definitions of restraints and enablers. Staff demonstrated good knowledge about restraints and enablers.  The restraint approval group forms part of the quality meetings. Restraint is also an agenda item at the staff meetings. Meeting minutes confirmed this.  A continuous improvement rating has been awarded for reducing the use of restraint at Annie Brydon from 19 in 2014 to no residents using restraint in July 2017. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | A signed job description for the restraint coordinator was evident in the CNM’s file and in the restraint folders. Responsibilities of the restraint coordinator and approval group are clearly outlined. Restraints to be used for the residents are approved by the restraint approval group prior to commencing the restraint, this includes the resident’s GP. The GP completes three-monthly reviews of the restraint in use.  Restraint use is discussed in the quality and staff meetings. Staff confirmed their knowledge of the restraint processes. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Restraint assessment forms, completed prior to commencing any restraint, was in the file of the one resident using restraint at Te Mahana, and residents who have used restraint in the past at Annie Brydon. Risk factors were identified in the assessment and the purpose of the chosen restraint was documented. Long term care plans clearly documented desired outcomes. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Safe use of restraint is actively promoted. The restraint/enabler registers are current and updated. The management plans include any risk factors and ensures the resident’s safety while using restraint. Staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. There are restraint minimisation policies and procedures that are accessible for all staff to read. There were no restraint-related injuries reported. There were monitoring forms for the resident who is using restraint and these were completed as required. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint use is evaluated at least three-monthly and the resident’s care plan six-monthly. Consents and evaluation forms were signed by the GP and the resident’s family/EPOA. The evaluation form included the effectiveness of the restraint and the risk management plan documented in the long-term care plan. Staff confirmed their feedback was obtained by the restraint coordinator when evaluating the restraint in use. Restraint in use is reviewed at the quality meetings. Meeting minutes confirmed this. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint approval group is responsible for monitoring and reviewing restraint. Restraint is also monitored through the internal audit programme. Identified issues are discussed in the quality and staff meetings as well as additional education that is required to support staff. Staff had good knowledge relating to managing challenging behaviour. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |
| --- |
| No data to display |

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

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.12.2  Consumers are supported to access services within the community when appropriate. | CI | Documentation in 2014 expressed some residents and their family’s desires to go out, however this was limited by the resident being in a wheelchair. Mobility taxis are not available in Hawera and the Annie Brydon van was cumbersome and often not available due to facility requirements and arranged outings.  A special purpose vehicle was purchased, especially designed to allow access to one resident in a wheelchair. It is easily operated, the back lowers to the ground and a ramp enables wheelchair access. The car can be booked by family members to enable them to independently attend functions and appointments.  The booking system and interviews evidences the ease of operation, the high usage of this vehicle and the advantages of the initiative. In addition to regular outings, residents have been enabled to attend appointments, out of town activities, anniversary’s, funerals, unveilings and numerous other events with their family and independently. There are currently seventeen residents at Annie Brydon who are utilising this vehicle on a regular basis for a variety of reasons. | A small vehicle capable of accommodating a wheelchair plus two other individuals has been purchased and enables easy access for individual residents and their families allowing residents the opportunity to go out independently. |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | CI | In 2016 Annie Brydon had six pressure injuries (PI). Three of those were facility acquired, the other three residents were admitted with the PI. The facility developed an initiative around zero tolerance to facility acquired PI and a commitment to minimise PIs and resolve PIs presenting on admission. Staff education, training sessions and awareness is constantly encouraged, including monthly team talks at handovers and ward meetings, staff newsletters, posters and on the floor training with the emphasis being on prevention. In 2016, four of the PIs were resolved, two residents died through other circumstances.  In 2017, Annie Brydon had seven PIs, three stage one PIs on one resident whom developed the PIs at Annie Brydon. The resident was non-compliant with turning regimes. With increased frailty, this resident has subsequently died. Four residents were admitted with PIs, two stage two and two stage one. All PIs have been resolved, bar one, who has a chronic medical condition that compromises the circulation. Photographs do however evidence ongoing improvement. Interviews and observation verify the facilities commitment to zero tolerance of PIs. | The service has a zero tolerance to pressure injuries. Since early 2016 the facility has resolved all but one pressure injury, through their commitment to preventative strategies, education, quality wound care management and zero tolerance. |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | CI | In 2016, the activities officers observed that twenty residents had no family or friends to visit. However, the pleasure gained by these residents when seeing children visit was noted. In addition, two residents, admitted into care were no longer able to attend the women’s division of the Federated Farmers club, of which they were life members, due to decreasing frailty. The recreation officer made contact with a local childcare centre and a primary school to initiate an ‘adopt a granny’ programme. The children visit monthly, enabling residents one to one interaction, playing a grandparent role.  The primary school has started up ‘secret writing buddies’. The children write about themselves (first name only basis) or write a story which the teacher drops off at Annie Brydon. The residents then read the children’s work and reply - if they are unable to write, a staff member will do the writing. At times, the children writing the books visits the residents and form a real connection.  Contact was also made with the women’s division of Federated Farmers and they were offered the lounge at Annie Brydon for their meetings. The group now hold their monthly meetings at Annie Brydon. The two residents have been enabled to keep up contacts and friendships with a community they have been part of for years. In addition to these woman, other residents have now joined the group.  Results: The residents look forward to the children’s visits. Residents who previously expressed a dislike of children and a reluctance to participate in most activities, now fully participate. The scheme has expanded so nearly all residents are now involved. The stories in the books enable residents to recall their childhood experiences, reminisce and share their life stories with the children. Residents state they feel valued as the children are listening and learning from them. The children’s reading and writing skills have improved. The stories have exposed residents to modern day technology hearing about Xboxes, Ps4s etc. Observations, documentation and interviews verify the pleasure residents and their families have gained from this initiative. | The activities programme at Annie Brydon has established connections with the community and improved the pleasure residents receive from exposure to children and to community involvement. |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | CI | Through analysing the monthly quality data, it was recognised that for a 68-bed facility, the level of restraint use at Annie Brydon was high. A quality initiative was developed by the clinical nurse manager with the aim of reducing the use of restraint. Discussions were held with staff, and further in-service education was provided relating to assessment and monitoring and seeking alternatives to restraint. Discussions were also held with residents and their families with regards to reducing restraint. High/low beds and sensor mats were acquired and put in place. Close monitoring of residents who were falling frequently was implemented including changing some resident’s rooms to an area where staff passed more often and observations during the night were increased.  All residents using restraint had comprehensive assessments completed with trends identified. Individual management plans were then developed and implemented. As a result of this intuitive, the rate of restraint use steadily decreased. From 2014 to 2015 the use reduced from 19 to 13. From 2015 to 2016 the rate decreased by half from 13 to seven. From 2016 to April 2017 the use reduced again to four and currently Annie Brydon is restraint free. Staff interviewed were very proud of this achievement and they were clear that they want Annie Brydon to remain restraint free. | A quality initiative was developed and implemented following recognition that restraint usage at Annie Bryon was high. Meetings and discussions were held and an action plan put in place to reduce the use of restraint. Further education for staff and alternatives to using restraint were implemented. As a result, restraint use has reduced by 100% at Annie Brydon and is currently restraint free. |

End of the report.