

Heritage Lifecare Limited - Annie Brydon Lifecare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Heritage Lifecare Limited

Premises audited: Annie Brydon Lifecare

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 11 October 2018 End date: 12 October 2018

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: 67

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

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

General overview of the audit

Annie Brydon Lifecare provides rest home and hospital level care for up to 71 residents. The service is operated by Heritage Lifecare Limited and managed by a facility manager and a clinical services manager, with support from a quality co-ordinator. Residents and families spoke positively about the care provided.

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

This audit has resulted in continuous improvement ratings in relation to links with family, quality management, the availability of hypo-glycaemic kits for diabetics on insulin, a new activities room and dementia group therapy initiatives. There were no areas identified as requiring improvement.

Consumer rights

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

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

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

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

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

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

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.	All standards applicable to this service fully attained with some standards exceeded.
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Heritage Lifecare Limited is the governing body and is responsible for the service provided at this facility. A business and quality and risk management plans are documented and included the scope, direction, objectives and values of the organisation. Systems in place for monitoring the services provided, including regular weekly and monthly reporting by the facility manager and quality manager to the governing body. The facility is managed by an experienced and suitably qualified manager.

A quality and risk management system is in place that includes annual planned audit activity, monitoring of complaints and incidents, health and safety, infection prevention and control, restraint minimisation and safe practice and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of trends and follow up where necessary. Meeting minutes and graphs of clinical indicators are displayed. Adverse events are documented and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. A suite of policies and procedures cover all necessary areas, were current and reviewed regularly.

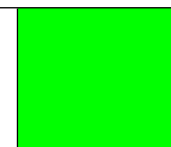
The human resources management policy based on current good practice guides the system for recruitment and appointment of staff. Orientation is provided. Staff training ensures staff are competent to undertake their role. A system is in place to identify, plan and facilitate ongoing education. The clinical services manager maintains all training records. Registered nurses are encouraged to undertake the interRAI training and competencies are maintained.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. The clinical services manager is on call out of 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 electronic and hard copy files.

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 the facility is appropriate and efficiently managed. When a vacancy occurs, relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers, communication sheets and stability of senior clinical staff guides 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 is overseen by a diversional therapist and a recreation officer and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van and a wheelchair accessible car is available for outings, with additional access to the village van available if required.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic 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, clean and meets food safety standards. Residents verified overall 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.

The facility has been purpose built. There are mostly single rooms with three double rooms designated for couples. All rooms are of an adequate size to provide personal care. The lease to occupy suites have their own bathrooms, bedroom and separate lounge/dining area.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are spacious and maintained at a comfortable temperature. Shaded external areas and seating is available.

Implemented policies guide the management of waste and hazardous substances. Personal protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All cleaning and laundry is undertaken on site with systems being monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to emergency power source is available when required. Residents reported a timely staff response to call bells.

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler was in use at the time of audit. No restraints were in use. Restraint would only be used as a last resort when all other options have been explored. A restraint register is maintained. Staff receive relevant ongoing training. Staff demonstrated a sound knowledge of understanding of the restraint and enabler process.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and appropriately trained infection control officer, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the Taranaki 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, data is analysed, trended, benchmarked 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	2	43	0	0	0	0	0
Criteria	5	88	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Annie Brydon Lifecare (Annie Brydon) 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 provided by the Health and Disability Advocacy Service, 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	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures and collection of health information.</p> <p>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 file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>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. The Advocacy Service attends residents' meetings yearly. Staff were aware of how to access the Advocacy Service.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>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. A facility van is available for outings and has recently had a hoist installed to enable wheelchair bound residents to participate in group outings. The ability for residents to maintain links with family and the community has been enhanced at Annie Brydon, by the continued commitment to the ongoing provision of a small vehicle that families can use to take residents out.</p> <p>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.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints and concerns policy which meets the requirements of Right 10 of the Code. There is a flowchart associated with the policy to assist staff in understanding the process for complaints management. The information is provided to residents and their families on admission and there is information and forms available in the information pack and forms were sighted in all service areas of the facility</p> <p>The complaints register reviewed showed that 10 complaints have been received over the past year and that actions were taken through to an agreed resolution. One recent minor complaint received has been investigated but has not been closed out at time of this audit. Appropriate timeframes specified in the Code were effectively met. Action plans reviewed showed any required follow-up and improvements have been made where possible.</p> <p>The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>The facility manager reported that there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, the District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members 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 and discussion with staff. The advocacy service attends the residents' meeting each year to ensure residents are kept informed. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families of Annie Brydon confirmed they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit, when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and discussion with families and the general practitioner (GP). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participating in community activities, regular outings to the local shops or areas of interest and participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>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.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There are five residents and at least nine staff at Annie Brydon at the time of audit who identify as Māori. Interviews with residents and staff verify staff can support residents who identify as Māori to integrate their cultural values and beliefs. Every file reviewed of residents who identified as Maori had a Te Whare Tapa Wha assessment in their care plan. 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, that includes a holistic Māori model of care.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents of Annie Brydon 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, for example, food likes and dislikes and attention to preferences around activities of daily living. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met, and this supported that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A GP also expressed satisfaction with the standard of services provided to residents.</p> <p>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 individual employment contract. Ongoing education is also provided on an annual basis (October), 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.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Annie Brydon encourages and promotes good practice through evidence-based policies and input from external specialist services and allied health professionals. For example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians, services for older people, psycho-geriatrician and mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for education. Education is provided internally, through in-service education by the clinical services manager (CSM), specialist speakers or access to on line learning 'hubs'. RNs can access training through the Taranaki District Health Board (TDHB), however generally use on line learning hubs or access to specialist advisors.</p> <p>Other examples of good practice observed at Annie Brydon included continuity of clinical expertise, with low staff turnover in key clinical roles. There is a commitment to ensuring all staff maintain their competencies</p>

		<p>regarding meeting clinical expectations. The CSM and assistant CSM assess all staff competencies. All care staff are medication competent.</p> <p>There are a number of ongoing initiatives aimed at reducing the number of falls, reducing the number of restraints in use and improving the management and healing time of a stage three pressure injury (incurred prior to admission that according to experts could not be healed) demonstrating a commitment to good practice at Annie Brydon.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members from Annie Brydon stated they were kept well informed about any changes to their own or 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.</p> <p>Interpreter services can be accessed via the TDHB when required. Staff knew how to do so and brochures on the service were easily accessible. Staff reported interpreter services were rarely required due to all present residents being able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	CI	<p>The business plan 2018-2019, which is reviewed annually for the organisation, outlines the purpose, values, scope, direction and objectives of the organisation. The facility manager, clinical services manager and the quality manager at Annie Brydon Lifecare also develop site specific objectives which link with the quality plan objectives. The documents reviewed described annual and longer term objectives and the associated action plan. The facility manager provides weekly reports on occupancy, health and safety, complaints and compliance issues (incidents/accidents), new risks identified and/or any outstanding issues, for example. The quality manager interviewed provides monthly reports to Heritage Lifecare Limited (HLL) directly to the national quality manager (NQM) including all clinical indicators and information provided from the clinical services manager. The information provided includes falls with and without injury, pressure injuries, infection rates and the narrative reports and data reports. The quality manager collates the information and provides all information in graph form prior to forwarding onto the national quality manager. Prior to reporting to the NQM the quality manager reports the results to the facility manager, clinical services manager and the staff directly. If any trends are identified at this stage a corrective action form is completed and actioned as soon as possible.</p> <p>The service philosophy is in an understandable form and is available to residents and family/representatives or other services involved in referring residents to the service. It is also documented in the information pack provided and reviewed.</p> <p>The service is managed by a facility manager who holds relevant qualifications. The facility manager is very</p>

		<p>experienced both in New Zealand and has overseas health experience in health management. Previously the facility manager was a needs assessment service coordinator and has been in this role for 10 months. The facility manager has attended relevant business management and aged related conferences and study days. The facility manager is supported by the quality manager and a clinical services manager.</p> <p>The service holds contracts with the district health board (DHB) for hospital care medical and geriatric, rest home residential care and respite care services. Seventy one (71) beds are available with three rooms designated for couples. On the day of audit there are 67 residents; 54 rest home, 11 hospital level care, one under 65 years (MoH YPD) (hospital) and one respite care (hospital). There are fifty four dual purpose beds and 14 dedicated rest home level care beds. Twenty four ORA rooms are included in the fifty four dual purpose beds.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the facility manager is absent, the clinical services manager carries out all the required duties under delegated authority. Support is also provided from HLL at all times. During absences of key clinical staff, the clinical management is overseen by a registered nurse who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement and is understood by the staff. This includes management of incidents/accidents, complaints and audit activities, an annual satisfaction survey, monitoring of outcomes, clinical incidents including infections and restraint minimisation and safe practice.</p> <p>Terms of reference and meeting minutes sighted confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs, and related information is reported and discussed at the weekly team meetings, and quality and staff meetings held monthly. Minutes reviewed included discussion on pressure injuries, restraints, falls, complaints, incident/adverse events, infections, audit results and the activities programme. Staff interviewed reported their involvement in quality and risk activities through audit activities, for example, for the laundry and the kitchen. Any relevant corrective actions are developed and implemented as necessary to demonstrate continuous improvement is occurring. Resident and family surveys are completed annually and are sent out from the HLL office. The last survey was completed in June 2018. The facility manager commented that there had been a smooth transition after the change of</p>

		<p>ownership, across all areas of service delivery.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements and were current. The document control system is managed at HLL head office by the NQM and quality team. All documents are updated as required and sent out via a memorandum with instructions for replacement in the manuals. The facility manager sends back a declaration that the documents have been updated on site. This process ensures a systematic and regular review process, referencing of relevant resources, approval, distribution and removal of obsolete documents. Staff are updated on any new policies or changes to policies through the staff meetings.</p> <p>The facility manager described the process for the identification, monitoring of risks and development of mitigation strategies. The risk register is updated at head office. The service risk register showed consistent review and updating of any risks identified, risk plans and the addition of any new risks. The facility manager, clinical services manager and the quality manager are aware of and have attended training in the Health and Safety at Work Act (2015) requirements and have implemented requirements. The clinical services manager is the health and safety coordinator/representative for this service.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>In December 2017, Heritage Lifecare Limited (HLL) developed and authorised a position of quality manager at Annie Brydon Lifecare as part of the transition process when purchasing this facility. The quality manager interviewed ensures any adverse event reported is dealt with immediately. Addressing incidents before they manifest into more significant events has proven to very valuable for the service. The aim of adverse event reporting is to close the 'quality loop' quickly and effectively. The incident management process is closely linked to the quality and risk management system. Evaluation of what corrective action has been developed and implemented and/or any trends identified are detected and actioned quickly. An incident register is maintained.</p> <p>A sample of incident forms reviewed show these were fully completed, incidents were investigated, actioned and follow-up was completed in a timely manner. Adverse event data is collated, analysed and reported by the quality manager to the facility manager monthly and meeting minutes reviewed showed discussion in relation to any trends, action plans and improvements made.</p> <p>The quality manager interviewed described essential notification reporting requirements. The service has had no notifications of significant events made to the Ministry of Health (MoH) since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	FA	<p>Policies and procedures are in line with good employment practice and relevant legislation and guide human resources management processes. Position descriptions reviewed were current and defined key tasks and accountabilities for the various roles. The facility manager is responsible for the recruitment process which</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>includes reference checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained. Employment checklists are used in the front of each individual staff record sighted. The records were maintained to a high standard.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed showed documentation of completed orientation and a performance review annually.</p> <p>Continuing education is planned on an annual basis. The in-service education schedule was sighted. Mandatory training requirements are defined and scheduled to occur over the course of the year. An education register has been developed and implemented for 2018 and a record is maintained by the clinical services manager. Competencies are maintained and were recorded on the competency register reviewed. Care staff have completed the required education to meet the requirements of the provider's agreement with the DHB. Education records reviewed demonstrated completion of the required training. Seven of eleven registered nurses have completed and are competent to perform interRAI assessments and two further staff are enrolled in the training. One enrolled staff member is an experienced enrolled nurse. Time is allocated to the staff for completing the required assessments.</p> <p>Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs and to review competencies. Appraisals were in progress at the time of audit.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day, seven days a week (24/7). The organisation (HLL) uses 'allocation of staff/duty rosters', an electronic tool based on indicators for safe staffing, and this is used by the facility manager and the clinical services manager when preparing the rosters. There is a documented rationale for safe staffing. The design of the facility and staff coverage for the twenty four (24) ORA individual suites which are built into the facility are taken into consideration when allocating the staff. All residents in the ORA suites are occupied by ARRC residents.</p> <p>The facility manager is able to adjust staffing levels to meet the changing needs of residents. An after-hours on call roster is in place with staff reporting that good access to advice is available when needed. The clinical services manager is on call and the newly appointed second in charge (2IC) will be sharing this role. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and families interviewed supported this.</p> <p>The rosters reviewed confirmed adequate staff cover has been provided with staff replaced in unplanned absences. There are two registered nurses on duty on the morning and afternoon shifts and two cover the</p>

		<p>night shift three nights per week and the other four nights an enrolled nurse is on duty with one registered nurse. The clinical services manager and the second in charge registered nurse work Monday to Friday during the daytime. Staff interviewed commented that any emergency situations are managed effectively. All staff have completed first aid courses and certificates were in the staff records reviewed. There are eleven registered nurses including the clinical services manager. All have competencies for medication management, verification of death, wound care management, female and male catheterisation and other medical and palliative care management roles.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels 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.</p> <p>Archived records are held securely on site and are readily retrievable using an electronic cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>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 CSM. They are also provided with comprehensive written information about the company, the service and the admission process.</p> <p>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 details, assessments and signed admission agreements in accordance with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge,</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the TDHB '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 the care plan 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 transfer was managed in a planned and co-ordinated manner. Family of the resident reported being kept well informed</p>

or transfer from services.		during the transfer of their relative.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>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.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>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 electronic medicine chart.</p> <p>There were five residents who were self-administer medications (inhalers) at the time of audit. Appropriate processes were in place to ensure this is managed in a safely.</p> <p>Medication errors are reported to the RN and CSM 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.</p> <p>Standing orders (nurse-initiated medications) are used, however these relate to each individual resident, and are documented on the individual's electronic medication chart.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p>	FA	<p>The food service is provided on site by a chef and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian in May 2017. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place, and due to expire 23 February 2019. A verification audit of the food control plan</p>

food, fluids and nutritional needs are met where this service is a component of service delivery.		<p>was undertaken on the 6 June 2018.</p> <p>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 chef has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>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.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>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 CSM. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents of Annie Brydon are assessed using a range of nursing assessment tools, such as pain scale, falls risk, skin integrity, nutrition, oral, risk screening and depression scale, to identify any deficits and to inform initial care planning. Within three weeks of admission residents are assessed using the interRAI assessment tool, to inform long term care planning. Reassessment using the interRAI assessment tool, in conjunction with additional assessment data, occurs every six months or more frequently as residents changing conditions require. A physiotherapist is employed by Annie Brydon, to provide physiotherapy services to residents twice a week. Residents are assessed by the physiotherapist on admission, with an ongoing plan put in place as indicated by assessment findings.</p> <p>Interviews, documentation and observation verifies the RNs are familiar with requirement for reassessment of</p>

		<p>a resident using the interRAI assessment tool when a resident has increasing or changing need levels.</p> <p>All residents had current interRAI assessments completed by one of seven trained interRAI assessors on site. InterRAI assessments are used to inform the care plan.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments are reflected in the care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. An initiative to manage a potential risk to insulin dependent diabetics, has been recognised as an area of continuous improvement.</p> <p>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 high 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.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a trained diversional therapist, who is also a trained physiotherapy assistant, and a recreation officer. Activities are provided five days a week, with additional events organised to occur over the weekend. Each day group and one on one sessions are provided.</p> <p>A social assessment and history are 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 regularly and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included daily exercise sessions</p>

		<p>run by the physiotherapy assistant, visits from local schools and kapa haka groups, visiting entertainers, quiz sessions, daily news updates and regular van outings. The activities programme is discussed at the minuted residents' monthly meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p> <p>A resident under 65 years, can access activities which meet the diverse needs of someone younger. Activity personnel spend additional time enabling the resident assistance with one to one activities, 'skype' calls to friends overseas, internet access, access to community events and time at home.</p> <p>The organisation's commitment to two initiatives involving enhancing residents' experiences around activities, and increased participation is recognised as an area of continuous improvement.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations 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 were sighted of short-term care plans being consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>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 or CSM sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the older persons' mental health services. Referrals are followed up on a regular basis by the CSM 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.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal. A contracted company removes all re-cycling and cardboard waste and normal waste is collected by the council weekly and as needed. There is a designated area for storing chemicals used for cleaning and the laundry which is securely locked. All containers in use are clearly labelled. An external company is contracted to supply and manage chemicals and cleaning products and they also provide relevant training for staff. Material data sheets were available where chemicals are stored and used and staff interviewed knew what to do should any chemical spill/event occur. Any related incidents are reported in a timely manner.</p> <p>There is adequate provision and availability of protective clothing and equipment and staff were observed using this including gloves, aprons and hats.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A building warrant of fitness is current and was displayed at the entrance to the facility with an expiry date of 16 October 2018. The facility manager explained that the required checks have been completed and the service is awaiting the new certificate through to 2019.</p> <p>Appropriate systems are in place to ensure the resident's physical environment and the facilities are fit for purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate and safe standard. The testing and tagging of equipment and calibration of medical equipment was current and confirmed in documentation reviewed, interviews with the maintenance person and observation of the environment. An equipment validation report was reviewed. All hoists are included in the checks and two oxygenators are ready for use. There are no oxygen cylinders on site but these can be ordered if and when required.</p> <p>The grounds are safely maintained and are appropriate to the resident groups and the setting. The environment is conducive to the range of activities undertaken. The environment was hazard free and residents were safe. Staff interviewed confirmed they knew the processes they should follow if any repairs or maintenance was required and that any requests are appropriately actioned. Residents reported they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate</p>	FA	<p>There is a mix of toilet, showers and bathing facilities. This includes rooms with ensuites, shared bathrooms between rooms and communal bathrooms. All individual resident's rooms have a hand basin. Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/accessories are available to promote residents' independence. The twenty-four (24) lease to occupy suites have their own bathroom.</p>

toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate space provided to allow residents and staff to move around within the bedrooms safely. All bedrooms provide single accommodation, with the exception of three designated rooms for couples. Shared approval has been sought. All rooms are personalised with furnishings, photographs and other personal items being displayed.</p> <p>There is room to store mobility aids, walking frames and wheelchairs. Staff and residents interviewed reported the adequacy of bedrooms. One motorised scooter and hoists sighted were stored in a designated area and did not impede walkways or create a hazard for mobile residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is one communal lounge available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs are met. The furniture is arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is undertaken on site in two dedicated laundries. Facilities are readily available in both laundries sighted. Resident's personal laundry items are laundered on site or by family members if requested. Residents and family members interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently washed by dedicated laundry staff during the daytime hours. The laundry person interviewed was very experienced. There is one designated staff member for the laundry and a relief laundry person available. After hours the care staff are responsible for the laundry. The staff member interviewed demonstrated a sound knowledge of the laundry processes, dirty to clean workflow and handling of soiled linen.</p>

		<p>There are three designated cleaners who are fully trained, including training on infection control, products and protocols. The cleaners cover the total facility inclusive of the ORA suites. Material data sheets are available for all products in use. A chemical spills kit is available if and when needed. The cleaning trolley is stored appropriately when not in use in one of the two locked sluice rooms. Chemicals are refillable, and all containers used were adequately labelled. Cleaning and laundry processes are monitored through the internal audit programme and by the company representatives.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning duties direct the facility in their preparation for disasters and describe the procedures to be followed in the event of fire or other emergencies. The current fire evacuation plan was approved by the New Zealand Fire Service, the most recent being the 17 July 2013. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being the 30 August 2018. The staff for the two sides or areas of the facility complete the drill. The local fire service attends the fire drills and provides feedback to the staff. The staff orientation programme includes fire and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water and blankets, mobile phones, torches, lanterns and gas barbecues were sighted and meet the requirements for seventy one (71) residents (including the 24 ARRC residents in the ORA suites within the facility). The emergency lighting which is regularly checked lasts approximately three to four hours. The service does not have a generator but is prioritised in the region for energy power supply as soon as available. Emergency protocols are linked with the DHB and Hawera Hospital if required and contact details of other aged care providers are accessible in the event of an emergency in this region.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families interviewed reported staff respond promptly to call bells.</p> <p>Security arrangements are in place and staff ensure all doors and windows are locked at a predetermined time in the evening and are again checked by the night staff routinely.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an</p>	FA	<p>All residents' individual rooms and communal areas have opening external windows with natural light. Gas heating is provided throughout the facility. Additional heat pumps are available in the communal areas. Areas are warm and well ventilated throughout the audit and residents and families confirmed the facility is maintained at a comfortable temperature.</p>

environment that is maintained at a safe and comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Annie Brydon provides a managed environment that minimises the risk of infection to residents, staff and visitors through 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 CSM. The infection control programme and manual are reviewed annually.</p> <p>The Clinical Services Manager (CSM) is also the designated infection control officer, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the quality/risk meeting. Infection control statistics are entered in the organisation's electronic database and benchmarked within the organisation's other facilities. The organisation's national quality manager is informed of any IPC concern.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control officer (ICO) has appropriate skills, knowledge and qualifications for the role. The ICO has undertaken post graduate 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 and expert advice from an external advisory company is also available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICO confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current</p>	FA	<p>The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were reviewed within the last year and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as was appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the</p>

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.		facility. Staff interviewed verified knowledge of infection control policies and practices.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by the infection control nurse from the TDHB and the ICO. Content of the training was documented and evaluated to ensure it was relevant, current and understood. A record of attendance was 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 a recent increase in urinary tract infections, and it was found to be related to a decrease in fluids being offered over winter.</p> <p>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.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>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 in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The ICO reviews 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 quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p>
Standard 2.1.1: Restraint	CI	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>provide guidance on the safe use of both restraints and enablers. A flow chart is also available to guide staff. The restraint coordinator provides support and oversight for enabler and restraint management in the facility when required and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the days of audit, no residents were using restraints. One resident was using an enabler which was the least restrictive and used in a voluntary capacity at the request of the resident.</p> <p>Restraint would only be used as a last resort when all alternatives have been explored. This was clear on review of the restraint approval group minutes and records reviewed and staff interviewed.</p>
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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	<p>Documentation in 2014 showed that some residents and their family's desires to go out, was limited by the resident being in a wheelchair. Mobility taxis are not available in Hawera and the Annie Brydon's 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. In 2017, there were seventeen residents at Annie Brydon who utilised this vehicle on a regular basis.</p> <p>A review of this initiative at audit identified the ongoing commitment to supporting resident's independence remains in place. 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,</p>	A small vehicle capable of accommodating a wheelchair plus two other individuals remains in operation at Annie Brydon. The availability of this vehicle enables residents and their families to access services within the community and to go out independently.

		unveilings and numerous other events with their family and independently. Family members are complimentary of the service identifying the vehicle as being small and compact, easy to park and easy to drive.	
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>The purpose, values, cope, direction and objectives of the organisation are clearly identified and regularly reviewed. The business plan and quality and risk plans are closely linked together to ensure objectives set can be effectively met by the service and the organisation as a whole. The governance and the facility management staff work closely together. The facility manager reports weekly to the organisation's national quality manager on all compliance issues, objectives set by the organisation and any adverse events, new risks identified or any outstanding issues. The quality manager reports monthly and covers all clinical indicators (provided by the clinical services manager) and relevant quality management data required. Any trends or outcomes are clearly identified and action plans are documented and action is commenced immediately on all outcomes to be addressed. All information is reported to the staff at the staff meetings and quality meetings held monthly. Objectives set by the service are closed out on the business plan once objectives have been met.</p>	<p>Having fully attained the criterion the service can in addition clearly demonstrate a review and analysis process of quality data, clinical and non-clinical, prior to reporting to the organisation's national quality manager. Comprehensive data was sighted. Graphs are developed from the information collated and evaluated. No time is wasted in putting into action, plans for any findings from the data collated and analysed. The quality manager performs this role monthly and reports back to staff all outcomes in the first instance, and develops corrective actions to be effectively met. This is completed and action is commenced on any outcomes before reporting onto the national quality manager which is unique for this service and organisation protocol reviewed.</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired</p>	CI	<p>The layout of Annie Brydon, and previous dealings with residents who had had episodes of hypoglycaemia identified a potential risk to insulin dependent diabetics, if they were to have a hypoglycaemic attack. The time taken for clinical staff to identify the cause of the event and access the basic equipment needed to manage the situation promptly, had been longer than advisable. An initiative was implemented, and hypoglycaemic kits were installed in all rooms of insulin dependent diabetics. All staff are trained in recognising the symptoms of hypoglycaemia.</p> <p>This initiative provides a benefit to the resident, by enabling the staff member to stay with the resident, rather than the resident having to</p>	<p>Hypoglycaemic kits are available in the rooms of residents who require insulin. This enables a prompt response from clinical staff should a hypoglycaemic event occur, therefore enhancing resident safety and reducing the potential impact of such an event.</p>

outcomes.		<p>be left while the staff member goes to get a kit from the treatment room. Each resident has their own personal blood glucose monitor in their kits, which they use daily. The kit also contains jelly beans, lancets, swabs and glucagon injections. The event is responded to promptly to enhance resident's safety. At present there are six residents who have kits in their rooms.</p>	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>Prior to dedicating a specific area to activities, activities were held in the two separate lounges of the facility. Two programmes operated, and each area generally did not mix. Visitors came and went, at times interrupting what activities were going on. Resident participation was low, an average of 248 overall attendances per month.</p> <p>Following a review, a new dedicated area was developed in the middle of the facility which is away from all the interruptions and heavy traffic flow areas. One programme is offered in this area and all residents are encouraged to attend. Resident numbers have increased to 948 overall visits in September 2018. Residents can display their work in this area and expressed pride when showing off their work. There is plenty of room for passive recreation, for those who would prefer to observe rather than participate. The room opens out into the garden, for the summer months. Families use the room for residents' celebrations, as observed on the day of audit when an extended family was lunching together. Residents mingle with everyone and lots of new friendships have been formed. Changing where the programme was presented has increased residents' desire to participate in the activities programme at Annie Brydon.</p> <p>The implementation of a dementia therapy group in the afternoon was implemented because of other residents complaining when residents with dementia became restless during afternoon activity sessions, or some residents fell asleep and then became restless overnight. The group was initiated by a caregiver who had been involved in a programme in another facility before. The staff member was relieved of caregiver duties and dedicated 1-2 hours per day spending time with residents with dementia. The group started with two in April and was up to seven in July 2018. Activities include</p>	<p>The dedication of a specific area to activities has enabled both areas of the facility to come together, and increased resident participation in the activities programme.</p> <p>The implementation of an activity programme specific to those residents with dementia, has improved their response to activities.</p>

		reading, listening to music, foot massage, walks, flowers, pictures, for example. Evaluations note that residents are more settled in the smaller sessions, are not so restless or sleepy, and sleep better at night	
<p>Criterion 2.1.1.4</p> <p>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.</p>	CI	<p>Records reviewed over the last year evidenced that since July 2017 until the present time no restraints have been implemented. A project commenced three years ago has seen the rate of resident restraint use slowly diminish from 8% in July 2017 to 0% at time of this audit. Increased family and staff education has been beneficial and increased awareness of how to manage any behavioural incidents. The falls rate has also decreased significantly along with residents not requiring a restraint. The quality manager ensures all incidents are followed up immediately and reported to the facility manager and clinical services manager. Any hazards are reported and eliminated. Records reviewed clearly evidence that discussions occur on how best to manage the individual resident to promote ongoing independence and safety. Staff interviewed are more aware of problem solving and looking for alternatives to restraint, rather than immediately resorting to the implementation of a restraint.</p>	<p>A continuous improvement rating is made as the organisation achieves beyond the expected full attainment. The restraint minimisation and safe practice programme is coordinated in a manner that promotes residents' safety and independence and promotes a team approach when managing individual residents to achieve their goals and objectives. A project introduced and the resulting action plan developed to reduce the number of residents on restraints has been managed effectively to achieve the current result of no residents using a restraint.</p>

End of the report.