Annie Brydon Complex Limited - Te Mahana

Introduction

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

The audit has been conducted by 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:	Annie Brydon Complex Limited
Premises audited:	Te Mahana Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 October 2019 End date: 8 October 2019

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: 23

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

Te Mahana Rest home provides residential services at rest home level care for up to 22 residents. The service is operated by the Annie Brydon Complex Limited and managed by a facility manager.

Residents and family members stated the care provided is of a high standard.

This unannounced surveillance 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 files, observations and interviews with residents, family members, the manager, staff, a general practitioner and two directors.

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.

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

The facility manager is responsible for the management of complaints and a complaints register is 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. A business plan including a mission statement, expectations and strategic direction and quality and risk management systems are fully implemented at Te Mahana. Systems are in place for monitoring the service, including regular reporting by the manager to the directors.

The facility is managed by an experienced facility manager who has been in the position for 13 years. The manager is supported by the directors, registered nurse and the health professionals from the medical centre close to the facility.

There is an internal audit programme. Adverse events are documented on incident/accident forms. Corrective action plans are developed, implemented, monitored and signed off as being completed to address any areas that require improvement. Staff and residents' meetings are held on a regular basis. Actual and potential risks including health and safety risks are identified and mitigated.

Human resources processes are followed. An in-service education programme is provided.

A documented rationale for determining staffing levels and skill mix is in place.

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.

A registered nurse and a general practitioner assist the team at Te Mahana with the assessment of residents' needs on admission. Care plans are individualised, based on a comprehensive range of information, including interRAI assessment outcomes and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Staff demonstrated a commitment to enabling residents to maintain their abilities and independence for as long as possible.

Members of the local community contribute towards ensuring a planned activity programme provides residents with a variety of individual and group activities.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. 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 is displayed. There have been no structural alterations since the previous audit.

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.		Standards applicable to this service fully attained.

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using a restraint at the time of audit and no residents using an enabler.

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.

An infection prevention and control programme is implemented by the facility manager who operates as the infection prevention and control coordinator. This includes infection surveillance. Advice is accessed from relevant professionals when needed. Infection surveillance is undertaken, and despite small numbers the data is used to promote applicable infection prevention practices. Staff are updated on the information obtained and follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	0	0	0	0
Criteria	0	39	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 1.1.13: 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 of Health and Disability Services Consumers' Rights (the Code). The information is provided to residents and families on admission and complaints information and forms are available at the main entrance. There has been one complaint since the last audit and this have been entered into the complaints register. The complaint was reviewed and actions taken were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaint management and follow-up. Staff interviewed confirmed a sound understanding of the complaints process and what actions are required. The facility manager reported there have been no complaint investigations to the Health and Disability Commissioner (HDC), the Ministry of Health, District Health Board (DHB), Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.
Standard 1.1.9: Communication Service providers communicate	FA	Residents and family members stated they are kept well informed about any changes to their own or their relative's status and 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

effectively with consumers and provide an environment conducive to effective communication.		supported by policies and procedures that meet the requirements of the Code. Interpreter services can be accessed via the community, families or the local DHB if required. Observation by the auditors evidenced effective communication and interaction between staff and residents. The residents, families and the GP confirmed this.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The business plan 2019-2021 outlines the strategic direction, expectations and sets out six result areas. The facility manager provides a monthly report to the directors. The directors meet with the facility manager on a regular basis and discuss the activities undertaken at the facility. Review of documentation and interview of the facility manager and two of the directors confirmed this. The directors have experience in owning and operating other aged care facilities. Te Mahana is managed by an experienced facility manager who was appointed to the position in December 2006. The facility manager has recently completed the Careerforce assessors' course and attends the two monthly forum meetings at the DHB. An RN who has interRAI competency is employed eight hours per week to provide RN input. There are five RNs working at the local medical centre who know all the residents and provide RN input as well. The medical centre is across the road from Te Mahana and the facility manager stated they are available should staff require any advice from an RN. The GP visits the facility monthly and reviews all residents residing at Te Mahana. The GP also visits any resident when there is a change in health status. The facility manager and GP stated the facility and the medical centre work closely together. On the day of audit all beds were occupied, plus one boarder. The service holds contracts with the local DHB for aged related residential care and carer relief. There were 22 residents under the aged residential care contract, no residents under the carer relief (respite) and one boarder.
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	FA	The organisation has a quality improvement plan-July 2019-June 2021 a mission statement, commitment, principles and objectives. Quality data for incident/accidents, satisfaction surveys, internal audits, infections and medication errors are being collected, collated and analysed to identify trends. Corrective actions are developed and implemented with monitoring to make sure corrective actions have been effective. Quality reports are completed monthly by the manager and include infections, accidents/incidents, restraints, pressure injuries and internal audits. Staff and resident meeting minutes reviewed evidenced regular reporting and review of data. Trends are identified that are generated month by month. The manager demonstrated knowledge relating to quality and risk management. Staff reported they are kept fully informed and discuss quality data at their meetings including trends and what corrective actions have been put in place.

principles.		The resident and family satisfaction survey for 2019 evidenced residents and families are very satisfied with the service provided. Policies and procedures are fully embedded at Te Mahana. They are relevant to the scope and complexity of the service, reflected current accepted good practice. Policies and procedures are reviewed two yearly and were current. Staff are alerted to any new or reviewed policies and are available for staff read and sign for. Staff interviewed confirmed this. Obsolete documents are removed and archived. Staff also confirmed the policies and procedures provide appropriate guidance for service delivery. A risk management plan is in place. Actual and potential risks are identified and documented. The hazard register includes clinical, environment, staffing and cleaning and laundry. The manager has overview of health and safety with a caregiver the health and safety representative and both are responsible for the management of hazards, including putting in place appropriate controls to eliminate or minimise all hazards on site. Interview with the manager confirmed this. Staff confirmed they understood and implemented the documented hazard identification processes.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Adverse, unplanned or untoward events are documented by staff on hard copy forms and are reviewed by the facility manager. The manager is responsible for the development of any corrective actions and close out. Review of the register, incident/accident reports and interview of staff indicated appropriate management of adverse events. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. Staff are aware of essential notification responsibilities. The facility manager stated there have been no essential notifications to external agencies since the last audit.
Standard 1.2.7: Human Resource Management Human resource management processes are	FA	Policies and procedures relating to human resources management are based on relevant legislation and good employment practices. Staff files reviewed included job descriptions which outline accountabilities, responsibilities and authority, employment agreements, references, completed orientation, performance appraisals and police vetting. New staff are required to complete an induction prior to completing the orientation programme. The entire orientation process, including completion of competencies, takes up to 11 weeks to complete and staff

conducted in accordance with good employment practice and meet the requirements of legislation.		performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Staff reported the orientation process prepared them well for their role. There is a focus on continuing education and care staff are encouraged and supported to complete a New Zealand Qualification Authority (NZQA) education programme. The manager is the Careerforce assessor for the facility and staff are encouraged to complete further levels. Currently three staff have attained level two and two have attained level three. The education plan for 2019 was reviewed and group sessions are provided mainly by the RN and external educators who come into the facility. Training is also provided at handover and staff meetings. Competencies were current, including medication competencies and restraint minimisation and safe practice. There is at least one staff member on each shift with a current first aid certificate. Staff files reviewed evidenced 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. Staff also confirmed their attendance at on-going in-service education and that their performance appraisal was current.
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 mix to provide safe service delivery. Currently the total number of staff employed is 15. The facility manager is full time and is rostered on call after hours for non-clinical matters. The RN is on-call for the clinical service. The RN is experienced in the aged care sector. District nurses also provided input and support. The work force is stable and most of the care staff have worked at Te Mahana for many years. There are two care staff rostered on the morning shift with another staff member who is employed to make the residents' beds. Two care staff are on the afternoon shift and one on at night. The kitchen has two cooks and two staff members who work over the evening meal service. There is a dedicated cleaner and care staff share laundry duties. Observations during the audit confirmed adequate staff cover is provided, including residents being helped with meals in a timely manner. Residents, families and staff interviewed demonstrated satisfaction with the staffing levels.
Standard 1.3.12: Medicine Management Consumers receive	FA	The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Medicines were stored safely in a locked medicine trolley, which is stored in a staff office that is locked when not occupied. Records of the temperatures of a small medicine fridge

medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		are checked and recorded nightly. Review of residents' medicine records and observation of a medicine administration round confirmed that safe systems for managing medicines are in place. The caregiver observed had a clear understanding of their roles and responsibilities. All staff who administer medicines are competent to perform the functions they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy or may be picked up. These are checked against the prescriptions and signed as correct by the facility manager who has a current medicine management competency and one other caregiver with a current competency. Clinical pharmacist support is available on request. All medications sighted were within current use by dates. Controlled drugs are stored securely in accordance with requirements and checked by two medicine competent staff that ensures accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart. Standing orders are not used. Self-medication processes are described in policy documents; however, there were no residents who were self-administering their medicines and the facility manager advised this is unlikely to occur and would be discouraged due to infrequent registered nurse cover. A medicine error specific accident and incident report form is available, and processes are in place for the analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is prepared on site by three experienced cooks, one of whom is well qualified. A menu has been developed in consultation with a registered dietitian, who has approved its suitability for meeting recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in November 2018. This was followed by a site visit for review of its implementation in January 2019 and the subsequent report from the dietitian stated good quality food is being provided to the residents who were happy with the meals provided and there were no recommendations. The residents and family/whānau confirmed their satisfaction with the meals during interviews. An advocate who leads residents' meetings once a month provides the residents with opportunities to feed back about the meals. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan that was verified by inspectors 29 April 2019. Food temperatures, including for high risk items, fridge temperatures, cleaning schedules and storage systems are monitored appropriately and recorded as part of the plan. All kitchen staff were assisted to undertake an on-line food safety training session in March 2019.

		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 the cooks and accommodated in the daily meal plans. Residents were seen to eat their meal in a relaxed manner with assistance provided when this was needed.
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 that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is much better than many places they had practised as a general practitioner. Care staff confirmed that care was provided as outlined in each resident's documentation and as directed by the facility manager, the registered nurse, or the doctors or nurses from the GP practice next door. An observation made during the audit was the frequency with which people were mobilised including with two-person assistance. A visitor interviewed noted the energy of staff in this facility, in particular, of the manager. Residents stated that they are assisted in every way possible and they are pleased with their decision to move into Te Mahana.
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 is primarily organised and/or provided by the facility manager with assistance from caregivers and volunteers from the local community. A social assessment is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activity support plans are developed and included interventions related to the following topics; creative, intellectual, individual, outings, social, physical, spiritual, cultural and other. Attendance records for activities were in all files reviewed. During the monthly residents' meetings with the local advocate/volunteer, the residents are asked for comment about the activities provided and asked for new ideas to ensure the programme is meaningful to the residents. These are documented and checked for their appropriateness in this setting. The resident's activity needs are evaluated six-monthly alongside the formal six-monthly care plan review. Residents interviewed suggested that sometimes there was more to do than others, but that a lot of visitors came, everyone got to know each other and they could choose what they did. Those who were local to the small town continue to attend village functions when capable. A formal monthly activity plan is developed by the facility manager and the one for October included key events of hairdresser visits, entertainment, church and board games, for example. Residents have the opportunity to participate in activities that varied from individual, group activities and local events. Despite the audit being unannounced, visitors and family members came and went all day. Volunteers assisted, read to residents, did puzzles with them, or took them for walks. A jigsaw puzzle was available, outings organised, and local community

		groups and services contribute to keeping residents occupied.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Evaluation of resident care occurs on a daily basis and reported in the progress notes at least once a day. If any change is noted, it is reported to the facility manager who contacts the GP practice, which is in close proximity to the facility. The registered nurse is informed when she comes on site. Formal care plan evaluations occur consistently every six months in conjunction. Comments are made against each goal in a specially designed 'evaluation of care plan' form. Where progress is different from expected, the service responds by initiating changes to the plan of care with the six-monthly interRAI reassessment, and as residents' needs change. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated, were noted for infections and wounds. Unresolved short-term problems may be transferred into the long-term care plan. Activity support needs plans are reviewed six-monthly alongside care plan reviews. Annual multi-disciplinary team reviews are being held, as are monthly or three-monthly medical reviews. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress, updates on the level of progress and any changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed at the front entrance of the facility. There have been no structural alterations since the previous audit.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the	FA	The infection surveillance process is described within the infection prevention and control programme in the infection prevention and control policy and procedure manual. Infections within the surveillance process are appropriate to those recommended for long term care facilities. All reported infections are documented and the GP or the registered nurse is consulted. Examples of short-term care plans implemented for management of infections were sighted in residents' records. The manager, in consultation with the registered nurse, operates as the infection prevention and control coordinator and reviews all reported infections. Details of any infections are listed on a monthly infection report and are analysed. Numbers are very small, therefore the opportunities for quality improvement are limited; however, the information is still reviewed and used to remind staff about preventive strategies. New infections and any required management plans and any preventive

infection control programme.		strategies are discussed at handovers and at monthly staff meetings. Examples of actions taken were reported with professional advice sought for one person with recurrent urinary tract infections that resulted in positive action. An observable rise in upper respiratory tract infections was attributed to seasonal risks and reminders of god hygiene practices were provided to staff and to residents.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator is the facility manager and this person demonstrated an understanding of the organisation's policies, procedures and practice and their role and responsibilities. On the day of audit, there were two residents using restraint. No residents were using an enabler. Equipment included sensor mats, so that restraint use is minimised. Regular training occurs for staff on restraint.

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.

No data to display

End of the report.