

# Bryant House Limited - Bryant House

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Bryant House Limited
<b>Premises audited:</b>	Bryant House
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 4 March 2020    End date: 5 March 2020
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	32

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Bryant House provides rest home and secure dementia care for up to 33 residents. The service is privately operated and managed by a general manager with assistance from a facility administrator support services coordinator and a clinical manager. Residents, families and the general practitioner interviewed 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, managers, staff and a general practitioner.

The audit has resulted in two continuous improvement ratings in relation to organisational management. 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.	Green	Standards applicable to this service fully attained.
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, dignity, independence and individuality. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a wide range of specialist health care providers to support best practice and meet residents' needs.

A complaints register is maintained with complaints 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.		Standards applicable to this service fully attained.
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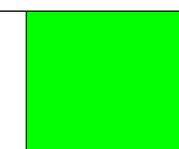
Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was comprehensive, regular and effective. An experienced and suitably qualified person manages the facility and is well supported by the management team.

The quality and risk management system include collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing education supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## 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.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including two registered nurses and general practitioner, assess residents' needs on admission. Care plans are individualised based on a comprehensive range of information 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. Residents are referred or transferred to other services as required.

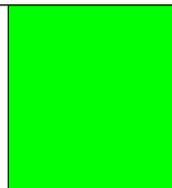
The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

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

The food services meet 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.

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas in both the rest home and dementia care service are accessible, safe and provided shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are fully trained in chemical management, emergency procedures, use of emergency equipment and supplies. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is well maintained.

## 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 organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process is documented to guide staff. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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



Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	2	91	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Bryant house rest home and dementia care 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 demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Residents and families interviewed confirmed this. Training on the Code is included as part of the comprehensive orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practices of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent had been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting Enduring Power of Attorney (EPOA) requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Reviewed resident files had copies of EPOA documents and shows evidence of activation of EPOA for mentally incapable residents. Staff were observed to gain consent for day to day care.</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>	<p>FA</p>	<p>During the admission process, residents/their family member/EPOA are given a copy of the Code, which also includes information on the advocacy services. Posters and brochures related to the advocacy services were also displayed and available in the facility. Family members and residents spoken with were aware of the advocacy services, how to access this and their right to have support persons.</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>	<p>FA</p>	<p>Residents are assisted to maximise their potential for self-help and maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities and entertainments. The facility has unrestricted visiting hours and encourages visits from residents' family members 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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that two minor complaints have been received over the past year and that actions taken, through to an agreed resolution are clearly documented within the timeframes required. Action plans showed any required follow-up and improvements have been made where possible. The general manager is responsible for complaints management and follow-up; however, the facility administrator support service's coordinator (FASSC) is responsible for maintaining the register. All staff interviewed confirmed a sound understanding of the complaint process and what actions are needed.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents interviewed reported being made aware of the Code and the National Health and Disability Advocacy Services (Advocacy services) through discussion with the staff and as part of the admission information provided. The Code is displayed on the notice boards at the entrance and communal 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 confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room with an ensuite or shared toilet.</p> <p>Residents are encouraged to maintain their independence through making choices around a wide variety of activities. There is safe access to outdoor areas for activities. Care plan included documentation related to the residents' disabilities, 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 interviews demonstrated that staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Staff education on abuse and neglect was confirmed to occur during orientation and annually.</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>Staff support residents in the service who identify as Maori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau. There is a current Maori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Maori in the facility. A Maori health plan was sighted in a Maori resident's file.</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 and family members verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed.</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. The induction process for staff includes education related to professional boundaries, expected behaviours, the Human Rights Act and the Code of Conduct. All registered nurses have records of completion of the required training of professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they should follow should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence-based policies, input from clinical nurse specialists and mental health services for older persons. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. The GP interviewed stated that Bryant House rest home and dementia care maintains a high standard of care.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practices. The registered nurse and nurse manager attend New Zealand Aged Care Association workshops, and education days conducted by the district health board and local hospice. There was evidence of in-house training facilitated by the clinical nurse specialist and hospice team.</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 stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meets the requirements of the Code.</p> <p>Interpreter services are available through the local district health board and staff knew how to access services, although reported this was rarely required due to all residents 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>	FA	<p>The Bryant House Rest Home Business Expansion Plan clearly identifies the purpose, values, scope, direction and goals of the organisation. The goals for the business plan are documented and were reviewed for 2020. The documents described annual and longer-term objectives and the associated operational plans. The general manager interviewed stated that the main goals and key focus for this coming year is to maintain the existing rest home, complete the retirement village and to start building the new rest home on the same site the second half of this year with a completion date of 2021. The plan was sighted.</p> <p>The service is managed by the general manager who is the owner director. The general manager (GM) and</p>

		<p>his wife have owned the facility since 2007. The general manager is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The general manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency with membership to the Aged Residential Care Association and attends meetings and conferences. The GM is supported by the clinical manager, who is an experienced aged care registered nurse who commenced the role on the 22 April 2019. The clinical manager manages the facility on a day to day basis and is supported by the FASSC</p> <p>The service holds contracts with the DHB for provision of rest home level care and stage 3 dementia care services. Thirty-two (32) residents were receiving services under the contracts; sixteen (16) rest home level care and seventeen (17) dementia level care The total beds available are thirty three (33). One rest home level bed was vacant on the day of the audit.</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 general manager is absent, the FASSC carries out all the required duties under delegated authority. The director is also available as necessary. During absence of key clinical manager there is a senior registered nurse (previously the clinical manger) who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff interviewed 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 comprehensive quality and risk system. A flow chart was reviewed to guide staff and to evidence the link with service delivery and health and safety. The risk management plan dated April 2019 was reviewed and reflected the principles of continuous improvement. The quality improvement plan was reviewed and stated there are six CQI objectives to meet this year. In addition to the plan the system also includes management of incidents and complaints, audit activities, a regular resident/family satisfaction survey, monitoring of outcomes, clinical incidents including any infections and restraint minimisation and safe practice.</p> <p>Policies and procedures sighted are all up to date. There is a documented control system which defines the stages in the documentation control process to ensure policies and procedures remain current. Staff are advised of any policy changes at shift handover and at the quality/staff meetings held two monthly. A quality consultant is contracted and was interviewed at audit. The FASSC is responsible for the policies and procedures being reviewed and the disposal and storage of any obsolete documents.</p>

		<p>Terms of reference and meeting minutes are reviewed and confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information is reported at the monthly quality and improvement management team meetings, and the two monthly inservice training and staff meetings. Minutes reviewed included discussion on any pressure injuries, restraint use, falls, complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk activities through these meetings. The GM stated relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Results of the above surveys showed satisfaction with service provision. Staff interviewed were satisfied with their roles and working conditions.</p> <p>The GM described the processes for the identification, monitoring and reporting of any risks and development of mitigation strategies. The hazard risk register was current and any identified risks were discussed at the three-monthly staff meetings. The GM interviewed was aware of the Health and Safety at Work Act (2015) requirements and has implemented all requirements.</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>	<p>FA</p>	<p>Staff document adverse and near miss events on the health and safety adverse event form. All incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. The FASSC collates all incident forms and the CM and senior RN complete the follow-up summaries and inform if any trends are identified. Family notifications were able to be verified. The FASSC collates the data onto a spread sheet and then develops the monthly and annual statistics summaries for both the rest home and the dementia service. Comparisons are made with the previous years' results (eg, 2018 and 2019 records were reviewed). Falls are documented under witnessed falls and unwitnessed falls and other incidents under appropriate headings, such as skin tears, pressure injuries, staff injuries and residents that 'go missing'. The summaries are presented at the two-monthly quality/staff meetings and meeting minutes showed discussion in relation to any trends, action plans and improvements made were documented.</p> <p>Policy and procedures described essential notification reporting requirements and the GM and CM were fully informed and described the essential notification reporting requirements. One pressure injury facility acquired has been reported to HealthCERT on a Section 31 Notice since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance</p>	<p>FA</p>	<p>Policies and procedures were in line with good employment practice and relevant legislation and guide human resource management processes. Position descriptions reviewed were current and defined as were the key tasks and accountabilities for the various roles. The employment process includes reference checks, police vetting, immigration status and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently</p>

<p>with good employment practice and meet the requirements of legislation.</p>		<p>implemented and records are systematically maintained.</p> <p>Staff induction/orientation includes all necessary components relevant to the role. Staff interviewed reported that the orientation process prepared them well for their role and included support from another staff member ('buddy' system) through their initial orientation period. Staff records reviewed showed documentation of completed orientation (an orientation checklist is in each staff record) inclusive of hand hygiene competencies and an appraisal completed after a three-month period and annually thereafter. All other competencies required are completed within three months of employment for care and household staff. Competencies are completed in both written and practical sessions.</p> <p>Continuing education is planned annually. Mandatory training requirements are defined and scheduled to occur over the course of the year. Education is also provided together with another aged care provider and this is well attended and received by staff. Care staff have either completed or commenced a New Zealand Qualification authority education programme to meet the requirements of the provider's agreement with the DHB. All staff who work in the dementia care service have completed the required training. The clinical manager is the educator for this service and is responsible for all staff education provided, competencies being completed, and educational records being maintained. Education records reviewed demonstrated completion of the required training. The clinical manager and the one registered nurse reported that the annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review of competencies. The clinical manager and the registered nurse attend regular aged residential care training and training at the Hawke's Bay District Health Board (HBDHB) and other elective training to meet their required education requirements for their annual practising certificates. Appraisals were current for all staff.</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 rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The policy identifies that the staffing levels reflect the number and mix of residents, acuity of residents, residents' care levels, layout and design of the facility, staff skills and experience. The appropriate skill mix was reflected on the two weekly rosters sighted. The CM is responsible to ensure that each shift is filled by staff with the appropriate experience and skills. Staff working in senior positions have the necessary qualifications and competence to do so. There is a household coordinator who is responsible for the cleaning and laundry services.</p> <p>There is also a compliment of household staff rostered on during the daytime hours. Staff levels observed reflected residents' assessed needs. In cases of emergencies, major infection outbreaks, or when a large number of staff are unable to fill their duties, appropriate replacements are sought. The last four weeks of rosters were reviewed. Care staff work across both areas of service delivery. Staff interviewed prefer this system as they get to know all residents and understand their individual needs. Residents and family/whanau supported this. Family interviewed with relatives in the dementia service stated that the staff are caring and</p>

		<p>use appropriate skills and techniques to manage the residents safely.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. Staff are always replaced for unexpected events such as sickness and planned annual leave. At least one staff member on duty has a current first aid certificate. During the day the FASSC takes all incoming calls to take the pressure off the clinical manager and the RN. The afterhours is shared between the CM and the RN. The CM works Monday, Tuesday, Thursday and Friday. The RN works Monday to Thursday.</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>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 general practitioner and allied health services provider notes. This includes interRAI assessment information entered into the Momentum electronic database. 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 a cataloguing system.</p> <p>Residents' files are held for the required period before destroyed. No personal and 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 are provided with written information about the services and admission process. There were evidences of obtaining EPOA/resident consents during 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, or</p>	FA	<p>Exit, discharge or transfer is managed in a planned and coordinated manner, with an escort as appropriate. The service uses the DHB's yellow envelope system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whanau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example of a resident referred to the NASC</p>

transfer from services.		team showed clear documentation and communication during the process. Interviewing the family confirmed that the family member was informed through the referral process.
<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 medicine management 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 blistered packed and are supplied to the facility from a contracted pharmacy. The registered nurse checks medications against the prescription. All medications sighted were within current use by dates.</p> <p>No controlled drugs were prescribed or stored on site on the days of audit. A secure controlled drug cupboard and a register to enter the stock were sighted. There was evidence of weekly and six-monthly stock checks when controlled drugs were used.</p> <p>The records of temperatures for the medication fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included 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 general practitioner review was consistently recorded on the online medication chart.</p> <p>There were no residents self-medicating on the day of audit and vaccines were not stored on site.</p> <p>There is an implemented system for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food services are provided on site by the kitchen team consists of two qualified cooks and three cooks and is in line with recognised nutritional guidelines for older people. Four weekly seasonal menu is in place. The evidences of review of regular dietitian review sighted. Recommendations made at that time have been implemented.</p> <p>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 and registration issued by the Napier City Council on 16 May 2019. Food temperatures, including high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff has undertaken relevant food</p>

		<p>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. Residents in the secure unit always have access to extra snacks to meet their nutritional needs.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents are seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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 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 changes 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. Example of this process has been witnessed during the audit days. The resident admission agreement has a clause 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>Information is documented using validated nursing assessment tools, such as interRAI, skin integrity, continence assessment, pain assessment, behaviour assessments, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by one of two interRAI assessors onsite. Residents and families confirmed their involvement in the assessment process.</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 were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. A daily management plan tool is used to summarise the 24-hour care needs of each resident. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>

		Along with the daily management plan, a comprehensive behaviour management care plan was sighted, triggers and de-escalation plan were clearly mentioned in the care plan. There were evidences of documenting challenging behaviours.
<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. 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 delivered according to instructions.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment including air mattress, pressure relieving cushions and other resources were available, suited to the levels of care provided and in accordance with the residents' needs. On the day of audit, no active pressure injuries were reported but care staff demonstrated knowledge in pressure injury management.</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 activity programme is provided by a trained diversional therapist holding the national certificate in diversional therapy and an activity assistant. Staff assisted activities are occurring during the weekends and after hours. The activities team set up activity's kits based on residents' social history and activities needs assessment. Care givers use these kits to keep the residents engaged.</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 residents' activity needs are evaluated on a daily basis and as part of the formal six-monthly care plan review. The facility encourages residents on a daily basis to be involved in community groups and events and day to day activities of living that support the residents' cultural, spiritual, activities of interest and their age.</p> <p>Activities reflected residents' goal, ordinary pattern of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whanau are involved in evaluating and improving the programme through day to day discussions and residents' meetings. Residents interviewed confirmed they find the programme good and look forward to going out.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery</p>	FA	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>plans are evaluated in a comprehensive and timely manner.</p>		<p>Formal care plan evaluations occur every six monthly in conjunction with the six monthly interRAI reassessment, or as needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whanau interviewed confirmed their 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>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a contracted GP service, residents may choose to use another medical practitioner. If the need for other non-urgent services were indicated or requested, the GP or RN sends a referral to seek specialist inputs. Copies of referrals to MHSOP and the dietitian were sighted in residents' files. The residents and the family/whanau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending to accident and emergency in an ambulance if the circumstance 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>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported in a timely manner. A waste management contractor is contracted to manage all waste. The local council recycling service is utilised appropriately. Material data sheets are available in the laundry and accessible to staff. No products are decanted other than under the manufacturer's instructions for cleaning, kitchen and laundry services. All staff have completed chemical safety training and records were reviewed.</p> <p>There is provision and availability of protective clothing which was observed in the bathrooms and throughout the service areas. Supplies are checked and purchased as required. Additional supplies are readily available at all times. Staff interviewed were aware of using protective clothing as required for different tasks for protection.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	<p>FA</p>	<p>A current building warrant of fitness was displayed that expires 20 November 2020. Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a maintenance programme in place for the building, equipment and any upgrading or renovations. Testing and tagging of essential equipment were current and on the maintenance plan. The GM is responsible for the maintenance programme.</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>There are external areas available that are safely maintained and are appropriate for the resident group. The environment is conducive to the range of activities undertaken. Residents are protected from risk associated with being outside.</p> <p>Residents interviewed confirmed that the accommodation met their needs and were observed to move freely around the facility. An outside area is provided for the dementia service with a telephone box, a bird aviary, bird bath, raised gardens, and other interesting activities are accessible. The home is in close proximity to an intermediate school and residents enjoy watching and hearing the children playing. Seating is available.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the rest home. There are toilets and bathrooms in close proximity to the residents' rooms in the dementia service. Coloured toilet doors and coloured doors to the residents' rooms ensure the residents get to know where their room is and location of the toilets. Appropriately secured and approved handrails are provided in all toilet/shower areas and other equipment/accessories are available to promote residents' independence.</p> <p>There is a staff and visitors toilet located near the laundry with a hand basin provided. Signage is available.</p>
<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>	<p>FA</p>	<p>There is adequate personal space provided to allow residents and staff to move around within the bedrooms safely. All bedrooms provide single accommodation. Residents spoke positively about their accommodation. Rooms are personalised both in the rest home and the dementia service with furnishing, photographs and other personal items. There is adequate storage for walkers, wheelchairs and total mobility scooters if needed.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are adequate and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. A library area was sighted and accessible for residents. Furniture is appropriate to the setting and residents' needs. It is arranged in a manner which enable residents to mobilise freely. The dementia service has a main lounge and a dining room available for residents. Both areas are comfortable with appropriate</p>

<p>appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>seating.</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>	<p>FA</p>	<p>All laundry is undertaken on-site by designated staff. Resident's personal items are also laundered on site or by family members if requested. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The household coordinator on duty interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. A contracted service provider is responsible for the refilling of the chemicals for the washing machines. The lint is also removed regularly from the clothes dryer as part of the maintenance programme.</p> <p>The household coordinator is responsible for orientating all new care staff to domestic duties. Part of this role is to ensure all equipment requiring temperature checks is undertaken and recorded appropriately. Supplies are ordered as needed for the cleaning, laundry and the kitchen services in a timely manner. All spare chemicals are stored in a locked labelled outside shed.</p> <p>Cleaning is undertaken daily by a caregiver allocated each shift to this role. All staff have received training for this role as verified in the training records.</p> <p>Cleaning, kitchen and laundry processes are monitored through the internal audit programme reviewed.</p> <p>The service demonstrated their commitment to the principals of health and safety and to providing a healthy and safe work environment.</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>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response were displayed and known to staff. Disaster and civil defence plans direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The GM was involved with the sign off of the HBDHB emergency plan. The current fire evacuation plan was approved by the New Zealand Fire Service on the 23 November 2009. Fire and evacuation training occurs six monthly, and a trial evacuation occurs six monthly with a copy sent to the New Zealand Fire Service, the most recent being on the 12 November 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Emergency flip charts were sighted in all service areas. The service has a business continuity plan which was reviewed as part of the obligations of the service contract with the DHB</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas barbeques were sighted and meet the requirements for the total number of residents. The civil defence supplies are checked regularly and recorded. There is no generator on site, but arrangements</p>

		<p>are in place if needed with another aged care service provider for any emergency. Emergency lighting exists and is checked regularly. Emergency bells are in all service areas and in the individual resident's rooms.</p> <p>A nurse call system is installed and the display board is near reception in the rest home. Audits are completed on a regular basis and residents and families reported that staff promptly respond to call bells.</p> <p>Appropriate security arrangements were explained by the general manager. Doors are locked by staff at 8pm in summer and 6.30pm in the winter. Security cameras are located throughout the facility with a back-up system being available if needed. A secure environment was observed in the dementia service with keypad access.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas have opening external windows and rooms open out with ranch sliders. Electric panel heaters are installed in all individual rooms and in the lounge/communal areas. On visual inspection areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.</p> <p>The clinical manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported to the quality improvement committee every two months. This committee includes the clinical manager, administrator/support services coordinator, diversional therapist, caregiver, general manager.</p> <p>Signage at the main entrance to the facility requests anyone who is, has been unwell, 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 responsibilities.</p>
<p>Standard 3.2: Implementing the infection control</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role for nearly a year. She has previous experience in a similar role and attended a relevant study day in February 2020. Additional support and information is accessed from the infection control support group at the</p>

<p>programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>district health board, the community laboratory, the general practitioner and public health unit as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreaks 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 accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The IPC policies reflected the requirements of the IPC standards and current accepted good practice. Policies were reviewed in December 2019 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. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Interviews, observations and documentation verified staff have received education in IPC at orientation and ongoing education sessions. Education is provided by qualified registered nurses. Content of training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Staff education is conducted based on the infection control trends identified. Staff were provided training on the recent Corona virus (Covid 19) outbreak.</p> <p>Residents were reminded of taking extra fluids during summer. An email has been send out to families in response to the recent Corona virus outbreak.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract infections, upper respiratory tract infection, skin/wound infections, eye, ear and nose and other</p>

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>infections. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced to compare the monthly infection data, and this is reported to the quality improvement committee.</p> <p>No outbreaks have occurred since the last surveillance audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service aims for a restraint free environment but does have policy and procedures to guide staff in the safe use of restraint should this be required. The CM/restraint co-ordinator discussed the alternatives to restraint and was clear about the process should anyone require restraint. This was confirmed with interviews with staff. The policy identified that the use of enablers was voluntary and the least restrictive option to meet the needs of the residents to promote independence and safety. There are no residents using enablers at the time of the audit and no restraints were in use.</p> <p>The families of residents in the secure dementia service are aware that this is a requirement for the unit to be safe and secure at all times for the residents. Keypad access is available.</p>

## Specific results for criterion where corrective actions are required

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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
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## 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
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	CI	<p>This is closely linked to 1.2.3.6. The quality and risk management system fully encompasses health and safety and all staff are fully emerged in the programme ensuring a safe environment for the residents, staff and visitors to the facility. Quality improvement of service provision is totally recognised and understood by the staff and management and is well implemented. Annual survey results are received, collated and analysed to ensure feedback is received from the residents and families. Staff did not always understand quality outcomes but the FASSC and the CM developed and implemented a quiz for all staff to complete after the quality/staff meetings. An initiative that is working effectively to raise awareness about quality and risk for all staff.</p>	<p>Having fully attained this criterion the service can in addition clearly demonstrate a review process that includes a system in place to ensure all staff are made fully aware of any policy updates, changes and/or results of the internal audits performed. The reporting and recording is very well documented. Staff are well informed of any corrective actions required when quality data results clearly identify there is a deficit in service provision and/or if a health and safety/quality improvement is required. The after staff meeting quizzes ensure all results and outcomes are understood and what changes have been made, to improve situations that arise are well communicated to staff, visitors and residents as necessary. A review of this process has occurred and feedback from staff, family and residents reflects that health and safety as part of the quality and risk management system has increased awareness of health and safety for residents and a safe environment is</p>

			continually maintained to benefit the residents as this is their home.
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	CI	<p>The organisation has a comprehensive planned quality and risk system that reflects the principles of continuous quality improvement. Monthly meeting minutes for the quality and improvement management team meetings confirmed regular review and analysis of quality indicators does occur monthly and that related information is reported and discussed at the quality /staff meetings held two monthly. Minutes of meetings were maintained and sighted at audit. Staff stated they did not always understand information fed back to them at meetings and those that did not attend the meetings did not always read the copies of the minutes provided in the staff room. The FASSC and the CM decided as an educational initiative/experiment to ensure staff were able to fully understand feedback of quality outcomes. The FASSC and CM decided to use a quiz post meetings for staff to complete using the minutes of the meeting held for rest home and dementia services. The quizzes were marked and results fed back provided to the individual staff.</p>	<p>Having fully attained the criterion, the service in addition can clearly demonstrate a review and analysis of quality data which is gathered from key components of service delivery and comparing data collected and identifying any trends or areas requiring improvement. Internal audits are performed and all records reviewed are comprehensive in detail and consequence if any risks are identified, for the size and nature of the services provided. Staff attend meetings and records are maintained. Staff have a responsibility to read the minutes of the staff/quality meetings held two monthly but this was not always occurring. The FASSC collates a quiz based on the minutes and other general business discussed at meetings and all staff have to complete this quiz and results are feedback to staff. Staff confirmed that they are up to date with all service changes and now feel very much more positive, interested and involved with the quality and risk management programme for this growing organisation.</p>

End of the report.