

Briargate Healthcare Limited - Briargate Dementia Care Unit

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:

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| Legal entity: | Briargate Healthcare Limited | |
| Premises audited: | Briargate Dementia Care Unit | |
| Services audited: | Dementia care | |
| Dates of audit: | Start date: 15 October 2020 | End date: 16 October 2020 |
| 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: | 32 | |

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 |
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|  | 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 |
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| 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

Briargate Dementia Care Unit provides secure rest home level dementia care for up to 40 residents. Two rest home level residents have permission granted by the district health board and Ministry of Health to be cared for at this facility. The service is privately owned by four owners. The owners have two aged care facilities. One of the owners has been appointed the facility manager from 01 April 2020 and a newly appointed clinical manager who is a registered nurse has been in the role since 01 April 2020. A resident and family members spoke positively about the care provided.

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 records, observations and interviews with residents, family members, management, and staff.

The previous audit identified 27 areas requiring improvement relating to consumer rights, governance, quality and risk, adverse event reporting, human resources and consumer information management. Improvements were also required in relation to care planning not reflecting interRAI assessments, evidencing all residents' have had their level of care assessed, planned activities, medication management, the food control plan, the residents' outdoor area, shower facilities and infection control. Two areas requiring improvement remain open; one relating to activities and the other relating to the need's assessment/admission documentation. In total twenty-five of the previous shortfalls have been addressed.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreter services if needed.

The administrator is responsible for the management of complaints with input of the facility manager and a complaints register is maintained.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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The business plans include the scope, direction, goals, values and the mission statement of the organisation. The facility manager/owner has ten years of experience in the aged care sector. The clinical manager is an experienced registered nurse and holds a current annual practising certificate. The current owner/directors have operated the business for ten years.

The quality and risk management system includes collection of quality data which can identify trends. Reporting to the governance group occurs. Adverse events are documented with corrective action plans now being implemented. Actual and potential risks, including health and safety risks are identified and mitigated.

The appointment of staff, orientation and management of staff is based on good practice. Staff training is planned and has been undertaken with gerontology nurse specialist input and the clinical manager has the responsibility for providing in-service education.

Staffing levels and skill mix meet the needs of the residents.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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A registered nurse and general practitioner assess residents' needs on admission. Care plans are individualised based on a range of information and accommodate any new problems that might arise. Records reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis.

The planned activity programme provided residents with a variety of individual and group activities.

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

The food service meets the nutritional needs of the residents with any special needs catered for. Food was safely managed, and in accordance with the approved food control programme.

Safe and appropriate environment

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

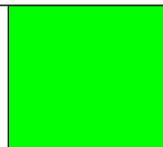


Standards applicable to this service fully attained.

The facility has a current building warrant of fitness. Electrical equipment is tested as required. Toilet and showers are all operable. The internal and external environmental areas are safe, with shade and seating made available for residents.

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.

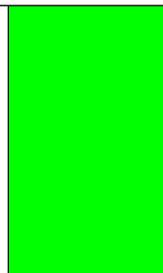


Standards applicable to this service fully attained.

No residents are using restraint or enablers due to the nature of this dementia service.

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 is appropriate for the size and nature of this dementia care unit. The programme is led by the clinical manager and aims to prevent and manage infections. The programme is reviewed annually.

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

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

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 21 | 0 | 1 | 1 | 0 | 0 |
| Criteria | 0 | 46 | 0 | 1 | 1 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
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| 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 |
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| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld. | FA | <p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to families on admission and those interviewed knew how to do so. The two rest home level residents interviewed who live at this facility with permission of the district health board (DHB) also are fully aware of their right to make a complaint and the process, and have no concerns or complaints.</p> <p>There were no records available since the previous audit until February 2020. There is a newly implemented complaints register which is maintained by the administrator and the owner/manager. There has been one verbal complaint and four minor written complaints received between February and October 2020. All have been dealt with appropriately and have been effectively addressed. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from the Health and Disability Commissioner, coroner's cases, police investigations, complaints from the DHB or other external agencies since the previous audit.</p> |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect | FA | <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Training has been provided since the last audit and 11 of 18 staff attended this workshop on the 22 October 2019. The workshop was provided by Age Concern Auckland's Elder Abuse Response Service and this training has been incorporated into the mandatory training schedule to be provided annually to ensure staff are fully informed</p> |

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| <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | | <p>and aware of their responsibilities in regard to this and to keep residents safe at all times in the service. The shortfall from the last audit has been addressed.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>Family members stated they were kept well informed about any changes to their relatives' health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported on the family/whanau communication record in the residents' records reviewed. Staff interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services although they were rarely used. Staff are able to provide interpretation as and when needed and the use of family members is utilised as needed.</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> | <p>FA</p> | <p>The Briargate Dementia Care Strategic and Business plan 2020 to 2022 was issued in May 2020. The plan outlines the mission statement and values of the organisation. The goals are divided into two strategic goals and workplace goals. There are comprehensive business strategic goals documented. The documents described annual and longer -term goals and the associated operational goals.</p> <p>The facility is managed by the owner/director who took over the facility manager role from 01 April 2020. The facility manager who has over ten years of experience in the aged care sector reports to the other three directors who also own another rest home in Auckland. Reports are provided on a regular basis to the governance group and records are now maintained. Minutes of meetings were reviewed including for quarterly reviews, annual reviews and monthly quality/staff meetings for staff which are held to ensure goals set are being met. Review meetings are attended by the clinical manager, facility manager, registered nurse and administrator. A quality monitoring programme has been implemented to monitor contractual and standards compliance and quality of service delivery. The two shortfall's raised at the last audit have been addressed.</p> <p>The clinical manager is a registered nurse who has recently been employed to the role. This person is experienced and holds relevant qualifications and has had previous aged care experience and clinical management experience. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The clinical manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing education. The position is full time Monday to Friday.</p> <p>The service holds contracts with WDHB and the Ministry of Health (MoH) for rest home level dementia care services which includes residents under 65 years of age (YPD), long term chronic health conditions and respite</p> |

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| | | <p>care for up to 40 residents.</p> <p>On the day of the audit, 30 residents were receiving services under the Age Related Residential Care contract for secure dementia care and two residents under the Long-Term Chronic Health contract rest home level care. These two residents have been granted permission from the DHB to stay at this facility.</p> <p>There were no residents under the MoH contract for Young Persons with a Disability.</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 now has a risk management programme that records the management of risks in the clinical environment, human resources management and other areas specific to the facility. Health and safety policies and procedures are now developed and implemented, and a hazard identification programme is also in place. Health and safety is monitored as part of the internal audit system and annual internal audits are implemented.</p> <p>Meeting minutes reviewed confirmed meetings are being undertaken to meet the policy requirements. Staff meetings were held monthly, and minutes of meetings were available for review. There is a set agenda to ensure all details are included and discussed at the meetings. Monthly quality data is now collated, analysed, evaluated and communicated and used for service quality improvement. A process to measure achievement against the quality and risk management plan is now implemented. Staff reported they are involved in quality and risk management activities through implementation of corrective actions which are presented at the daily handover as and when required. The clinical manager is responsible for signing off any corrective action follow-up and this was reviewed at audit.</p> <p>A quality consultant has implemented a new system for all policies and procedures. The policies are tailored and relevant for an aged care dementia service. Staff have been updated with all new policies and procedures through staff meetings and policy folders in the nurses' station. All policies and procedures have been implemented with supporting documents (e.g. incident forms, staff meeting forms, internal audit and corrective action forms, complaint forms) and other human resource management documentation. A document control system is now established and implemented. The cultural safety section is the only policies to be reviewed. The policies meet all contractual requirements including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Obsolete documents are being removed from the system.</p> <p>The facility manager and the clinical manager described the processes for the identification, monitoring, review and reporting of risks and development for mitigation strategies. They are both familiar with the Health and Safety at Work Act (2015) and have implemented all requirements.</p> <p>The seven areas identified as requiring improvement at the last audit have been addressed.</p> |
| Standard 1.2.4: | FA | Staff document adverse and near miss events on the new accident/incident forms implemented. A sample of |

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| <p>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>accident/incident forms showed that family were being informed about any events that occurred. Family interviews confirmed this did occur in a timely manner. If a corrective action is required following an accident or incident it is documented in the resident's clinical records and staff are informed at handover of the required actions to be taken. The accident/incident forms are reviewed by the registered nurse and the number for each type of incident is recorded. Adverse event data is collated and analysed by the clinical manager and reported at the staff/quality meetings held monthly.</p> <p>The clinical manager described essential notification reporting requirements including for pressure injuries. The clinical manager and registered nurse were fully informed about essential reporting. There have been no Section 31 notices reported to HealthCERT, MoH or any other agencies since the previous audit.</p> <p>The two areas identified as requiring improvement at the last audit have been addressed.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>Human resource management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police checks and validation of practising certificates (APCs) where required. A sample of records reviewed confirmed the organisation's human resource management policies are being implemented.</p> <p>Staff orientation includes all necessary components relevant to the role. Care staff reported that the orientation process prepared them well for their role. All staff records evidenced documentation of completed orientation and a performance review after one year. The clinical manager has completed a full orientation and a job description was reviewed.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The education calendar for 2020 showed that documented education has occurred. The DHB gerontology nurse specialist provides in-service education and feedback is sought after all presentations. Ten care staff have completed the required New Zealand Qualification Authority dementia education programme and two are enrolled for 2021. This is in order to meet the provider's agreement with the DHB. The newer care staff work alongside senior caregivers/team leaders until they have completed the required training. The clinical manager and the one registered nurse maintain their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of annual performance appraisals.</p> <p>Two areas identified as requiring improvement from the previous audit have now been addressed.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p> | FA | <p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. Rosters are now displayed two weeks in advance in the 'B wing' nurses' station. The clinical manager is on call for clinical matters 24 hours a day, seven days a week (24/7). Care staff reported that</p> |

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| <p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | | <p>good access to advice is available. Team leaders have been appointed to the shifts and this system is working effectively and the senior care staff are aware of the additional responsibilities with this role. Family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided with care staff replaced as needed for unplanned absences. The service has a new activities coordinator since the previous audit who works 9 am to 5 pm Monday to Friday. At least one staff member on duty has a first aid certificate. Experienced staff cover the kitchen, cleaning, and the laundry services daily seven days a week. The registered nurse works Thursday to Monday and the clinical manager works Monday to Friday full time. Because resident numbers are currently 32, there are three care staff on the morning shift 0645 am to 3.15 pm, three care staff on the afternoon shift 2.45 pm to 11.15 pm and two caregivers at night 11 pm to 7.15 am. The care staff numbers will increase as the number of residents' increase. No agency staff have been employed at the facility.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | <p>FA</p> | <p>The information record for each resident was generated from the interRAI system. No information of a private nature was displayed in public view. The current resident records are stored in the locked nurse station. The record system for archiving records has been established and a retrieval system developed and implemented. Records reviewed by sample were legible and labels were in place on all pages required. The areas identified as requiring improvement at the last audit have been addressed.</p> |
| <p>Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | <p>PA Moderate</p> | <p>Two long term residents have been assessed as requiring rest home level care, and approval has been provided by the District Health Board for these two residents to stay at Briargate Dementia Care Unit. Records were not available to demonstrate the outcomes from the Needs Assessment and Coordination Centre assessments/specialist referral for two other residents. A completed admission agreement was unable to be located for four residents including the resident audited using tracer methodology receiving dementia level of care. This resident was also missing completed consent documentation in records available. This continues to be an area requiring improvement.</p> |
| <p>Standard 1.3.12: Medicine Management Consumers receive</p> | <p>FA</p> | <p>The medicine management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A system for medicine management using an electronic system was observed on the days of the audit. The staff</p> |

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| <p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>observed demonstrated good knowledge and had a clear understanding of the role and responsibilities related to each stage of medicine management. All staff who administer medicines were competent to perform the function they manage. This now meets the standards.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. An RN and another staff member check the medication against the prescription before being placed into use. The staff members administering the medicines also checked this prior to administration. All medications sighted were within current use by dates.</p> <p>There were no residents receiving controlled drugs at the time of audit. The controlled drug register was sighted and contained appropriate documentation including weekly checks for when CDs were last in use.</p> <p>The small fridge used for medicines was checked daily and the temperature was recorded. Vaccines are not stored on site. The medicine trolley was stored in a locked room when not in use.</p> <p>Good prescribing practices were noted on the electronic system and evidenced three monthly reviews occurred. Any allergies and sensitivities were recorded. All requirements for pro re nata (PRN) medicines were met. Evaluation is occurring assessing the outcome of PRN medicines given for nine of the 10 applicable events. The event that had not been evaluated was for the administration of PRN paracetamol. The CM reviews the use of PRN medicines via the reports available via the electronic medicine management programme. This shortfall from the last audit has also been addressed.</p> <p>There were no standing orders and no residents who were self-administering medications. There is a documented process for any medication errors to be reported and analysed.</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> | <p>FA</p> | <p>The food service is provided on site by one of two cooks, who are supported daily by a kitchen hand. Food services are in line with recognised guidelines for older people. The menu has been reviewed by a dietitian in August 2019. The daily menu is displayed for residents. The cook and kitchen hand were interviewed.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The main cook orders the foods required and purchases fresh fruit and vegetables weekly, meat every 10 days and bread, milk and dairy products three times a week. The service operates with an approved food safety plan (expiry 11 September 2021), and has been audited against the food control plan in May 2019. The service is due a reaudit of their food control plan by the end of October 2020, and communication with Auckland City Council commenced in August 2020, planning for this reaudit. Food temperatures were monitored appropriately and recorded as part of the plan. The kitchen staff have completed food safety courses.</p> <p>A nutritional assessment is undertaken for each resident on admission by a RN/CM and the dietary profile is developed and updated as required. The personal food preferences or any special diets or modified textures</p> |

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| | | <p>required are made known to the cook and accommodated daily.</p> <p>Evidence of resident satisfaction with meals was verified by a resident and family members interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring any assistance had this provided. Residents are provided with breakfast as they arrive in the dining room at their leisure/convenience. One resident interviewed confirmed a preference to eating much later than all the other residents and staff provided individual meals based on the resident's spiritual needs and preferences. Care staff and kitchen staff verified food is available for residents 24 hours a day, and examples were documented in sampled residents' records of food and beverages being provided in the evening and during the night.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>Documentation, observations and interviews verified the care provided to residents was consistent with meeting their needs, goals and the plan of care. Assorted policy and procedures are available to guide care staff. The attention to meeting the individualised needs was evident in all areas of service provision. The RN and CM and care staff confirmed at interview that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the rest home and secure dementia level care provided and in accordance with the residents' needs. There are appropriate clinical, wound care and continence supplies available.</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> | PA Low | <p>Two full time staff are involved with providing the activities and recreation programme. The shortfall from the last audit has been addressed. Comprehensive assessments are used to inform the development of individual and group activities and residents' participation is actively monitored. The individualised assessment and plans do not describe how the routine of each resident is best managed over a 24 hour period, including identification of individualised diversion, motivation and recreational therapy as required by the aged related residential care contract for residents receiving dementia level of care. This is a new area identified as requiring improvement. However, staff were observed engaging positively with residents, and providing a variety of fun and interactive activities and responded well to changes in each resident's interest and behaviour.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p> | FA | <p>Residents' care is evaluated on each shift and reported in the progress records. If any change is observed, it is reported to the RN. The 'stop and watch' tool is in use.</p> <p>Formal care plan evaluations are occurring every three months in conjunction with a range of Briargate nursing assessment tools, and six monthly in association with the interRAI reassessments, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans are used for any problems/issues that may arise and these are consistently evaluated as clinically</p> |

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| <p>timely manner.</p> | | <p>indicated, for example, urinary tract infections, and following a fall. When necessary and for unresolved problems, long term care plans were added to and updated. In addition, a range of tools are used to monitor applicable resident's dietary and fluid intake, behaviour, and continence/toileting. Admission, and subsequently at least monthly vital signs and weights are recorded. Neurological observations were undertaken following a resident fall. Residents and families interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>The GP and podiatrist document their assessment and evaluation at the time of each consultation.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>A current building warrant of fitness (BWOFF) dated expiry 23 January 2021 was publicly displayed in the entrance to the facility.</p> <p>Appropriate systems are in place to ensure the residents' physical environment is fit for purpose. The testing and tagging of equipment was current as confirmed in the documentation reviewed and observation of the environment. The environment was hazard free, residents were safe and independence was promoted. The outside large deck for residents to walk out onto is totally secure with adequate seating and a large table with sun umbrellas. A shade sail has been installed which covers part of the area providing further shade for the warmer weather. Planters are also in place for residents to enjoy and to use for outdoor activities. The shortfall raised at the last audit has been addressed.</p> <p>Repairs and maintenance are undertaken as needed. Residents were observed using the outdoor area provided and family members interviewed were happy with the environment.</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</p> | <p>FA</p> | <p>There are adequate toilet facilities and hand basins. Hand basins are located in each bedroom. The three shower areas are now all operable. The work required was completed November 2019 and the three bathrooms were observed to be fully utilised on the day of the audit. This was an area identified for improvement at the previous audit which has now been addressed.</p> |

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| requirements. | | |
| <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 manual with all relevant policies and procedures to support staff. The manual and plan are reviewed annually. The clinical manager is responsible for the programme implementation and is the designated infection control nurse (ICN). The role and responsibilities are part of the ICN job description. Infection control matters, including surveillance, are discussed at the staff monthly meetings. The shortfall from the last audit has been addressed.</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> | FA | <p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. These are dated as developed in September 2019 and reflected current accepted practice. A copy of all policies is available for staff to review/access and are discussed at staff orientation and ongoing education sessions. The shortfall from the last audit has been addressed.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant</p> | FA | <p>The clinical manager has attended training relevant to this role prior to her employment at Briargate. Interviews, observation and documentation verified all staff have received education in infection prevention and control at orientation and via ongoing education sessions. A significant amount of the education has related to hand hygiene, use of personal protective equipment (PPE), including the correct donning and doffing technique, and</p> |

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| <p>education on infection control to all service providers, support staff, and consumers.</p> | | <p>Covid-19, has occurred in 2020 to date. The education was provided by the clinical manager and based on the updated information received from the Ministry of Health, the DHB, the New Zealand Aged Care Association, and public health service. All communications received related to Covid-19 repose are held in folders. Content of training is documented to ensure it is relevant and current. A record of attendance is maintained. There have been no outbreaks of infection since the last audit. The shortfall from the last audit has been addressed.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | <p>FA</p> | <p>Surveillance is appropriate to that recommended for an aged care residential service and included infections of the urinary tract, soft tissue/wounds, eye, gastroenteritis, upper and lower respiratory tract and skin infections. The clinical manager reviews all reported infections, and these were documented. Any new infections and any required management plan are discussed at the handover between the shifts to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated by the clinical manager and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via the staff meetings and at staff handover. Graphs were produced that identified numbers and trends of infection each month year to date. This is also observed to be displayed in the staff office area. The shortfall from the last audit has been addressed.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical manager is the restraint coordinator and demonstrated a sound understanding of the organisation's policies, procedures and practice for this role.</p> <p>On the day of audit, no residents were using a restraint or an enabler. This is a dementia unit, and a restraint free environment is provided. Safety of residents is paramount.</p> |

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.

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p> | <p>PA</p> <p>Moderate</p> | <p>The clinical manager advised residents enter the service when their required level of care has been assessed by a specialist 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 (if able due to Covid-19 level restrictions) and are provided with written information about the service and the admission process. All current residents are receiving long term services.</p> <p>Specialist referral letters and records of the outcome of residents' needs assessments are located in several locations. Some records were electronic, some records were in archived files, while other information was in the residents' current files. For some residents the information was in a separate folder in the manager's office. A completed needs assessment and/or specialist referral documentation to the service was initially unable to be located for seven residents. The DHB needs assessment service subsequently provided some documents for five of these residents including the resident audited using tracer methodology who was confirmed as requiring dementia level care. Some of the DHB information arrived just</p> | <p>Records detailing the outcomes of the Needs Assessment and Service Coordination (NASC)/specialists referral process was not able to be verified for two residents whose files were reviewed. A completed admission agreement and consent form could not be located for the resident audited using tracer</p> | <p>Ensure the outcome of the Needs Assessment and Service Coordination outcomes /specialist referral are readily available, along with admission agreements and consent forms for all residents receiving care.</p> |

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| | | <p>prior to the audit closing meeting. The specialist referral documentation was also located for the resident audited using tracer methodology. However, confirmation of the assessment/referral documentation related to the level of care was not able to be verified for two residents who were admitted in 2014 and 2017. This was not raised as a high risk corrective action, as the DHB advised prior to audit that they had followed up the two residents that did not have appropriate assessment documentation as identified during the last audit. These two residents were receiving care at that time. The facility manager advised these two residents had been assessed and referred by appropriate specialist for dementia level care, and the issue was not related to a lack of assessment/appropriate referral but rather related to Briargate's historic records management processes which are in the process of being standardised.</p> <p>Two long term residents have been assessed as requiring long term rest home level care, and dispensation has been received from the DHB allowing this. The completed needs assessments for these two residents were sighted. The residents and their enduring power of attorney have signed consent forms confirming it is their choice to stay living within the secure dementia unit although secure dementia level of care is not required by them.</p> <p>A completed admission agreement and completed consent forms could not be located for the resident audited using tracer methodology receiving dementia level of care. Admission agreements were not able to be located for three other residents. The clinical manager has been reviewing the admission NASC documentation, admission agreement and enduring power of attorney information for all current residents and has developed registers with this information as documents are located and noting and following up on the gaps in the information available.</p> <p>Family members interviewed in person and by telephone stated that they were satisfied with the admission process and the information provided to them.</p> | <p>methodology who was receiving dementia level of care. Admission agreements were not able to be located for three other residents.</p> | <p>90 days</p> |
| <p>Criterion 1.3.7.1 Activities are planned and</p> | <p>PA Low</p> | <p>On admission, a comprehensive assessment is completed for each individual resident, identifying their interests, hobbies, functional abilities, social history, and family history. An individualised activities plan is</p> | <p>Plans have not been developed to describe how the</p> | <p>Individualised plans are developed that</p> |

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| <p>provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p> | | <p>developed based on the assessment, with both group and individual activities planned and provided. However, this individualised assessment and plan does not describe how the activities/behaviour of the resident is best managed over a 24-hour period, including identification of individualised diversion, motivation and recreational therapy as required by the aged related residential care contract. This was not present for any of the dementia level care residents sampled and as verified by the clinical manager interviewed. A template for this assessment and care plan was subsequently located in the new policy and procedure manual but had not been implemented.</p> <p>The Briargate Dementia Care Unit activities plan is developed monthly and communicated to residents each day. The activities plan includes weekends with a range of activities listed that can be facilitated by the caregivers on duty. Attendance at activities is recorded daily on a monthly attendance register, along with a daily evaluation of the resident participation in activities provided. There are two full time staff involved in providing activities which is overseen by the life enrichment coordinator (employed in February 2020). The life enrichment coordinator has a diploma in sports and recreation. There is a facility van which can take five residents and the driver and one caregiver on daily weekday outings. The activities programme is varied, is adjusted on a daily basis based on the resident's participation or vocalised interests. This was observed during audit when a resident was talking about aeroplanes. This resulted in a spontaneous change in the planned activities and up to ten other residents joined in, with other staff assisting with providing activities for the other residents. The activities provided reflected residents' goals, and ordinary patterns of life. There are a range of art/craft, puzzles, games, music, virtual tours and exercise activities occurring with visiting entertainers and pet therapy when Covid -19 precautions permit. Residents' birthdays are celebrated along with other days of spiritual and cultural significance.</p> <p>A resident and all eight family members interviewed stated that the activities programme is engaging, well planned and efficiently undertaken and meets the needs of the residents.</p> | <p>behaviour/routine of individual residents are best managed over a 24 hour period, including identification of individualised diversion, motivation and recreational therapy as required by the aged related residential care contract for residents assessed as requiring dementia level care.</p> | <p>describe how the behaviour/routine for each resident receiving dementia level care is best managed over a 24-hour period, including identification of individualised diversion, motivation and recreational therapy.</p> <p>180 days</p> |
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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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.