

# Heritage Lifecare Limited - Annie Brydon Lifecare

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Heritage Lifecare Limited

**Premises audited:** Annie Brydon Lifecare

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

**Dates of audit:** Start date: 3 February 2021      End date: 3 February 2021

**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:** 69

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

## General overview of the audit

Annie Brydon Lifecare provides rest home and hospital level care for up to 71 residents. The service is operated by Heritage Lifecare Limited and managed by a care home and village manager. The care home and village manager is supported by the clinical services manager. Residents and staff 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, managers, staff, contracted allied health providers and a general medical practitioner.

There were no areas for improvement requiring follow-up from the previous audit. Two areas were identified for improvement at this audit in relation to care planning and medication management.

## Consumer rights

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

A complaints register is maintained with complaints resolved promptly and effectively. No external complaints have been received.

## 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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Heritage Lifecare Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Annie Brydon Lifecare and include a mission statement, philosophy scope, objectives, values, and goals. Systems are in place for monitoring the service, including regular reporting by the clinical services manager to the regional quality manager.

The service is managed by an experienced care home and village manager. The care home and village manager is supported by a clinical services manager who has oversight of all clinical services in the facility.

Quality and risk management systems are followed. There is an internal audit programme. Adverse events are documented on accident/incident forms. An incident register is maintained. Accident/incident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Staff, registered nurses and resident meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks.

Policies and procedures on human resources management are in place and processes are followed. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are always rostered on duty. The clinical services manager and senior nurses cover the on-call after hours for clinical issues and the care home and village manager is available for any non-clinical issues that may arise.

## 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.		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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Residents of Annie Brydon Lifecare have their needs assessed on admission by the multidisciplinary team. Assessments occur within the required timeframes. Shift handovers and communication via an electronic 'message board' guides continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents and family members interviewed reported being well informed and involved in care planning and evaluation, and that the care provided by the staff is of a high standard.

The planned activity programme is provided by a diversional therapist and a recreation coordinator. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures and consistently implemented using an electronic system. Medications are administered by registered nurses, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is displayed at the front entrance. Preventative and reactive maintenance programmes include equipment and electrical checks.

## 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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Three enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Surveillance of aged care specific infections is undertaken at Annie Brydon Lifecare. Results are analysed, data is trended and benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	0	2	0	0
Criteria	0	38	0	0	2	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The care home and facility manager (CH&amp;FM) is responsible for the management of complaints. The complaints and compliments forms and associated documents meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (The Code). Information on the complaint process is provided to residents and families on admission and was available throughout the facility. Residents and families interviewed knew how to make a complaint and to provide compliments.</p> <p>The complaints register evidenced ten complaints have been received in the last year and that actions were taken through to an agreed resolution, were documented and processes completed within the timeframes required. Action plans showed any required actions or improvements that have been made where possible. Complaints are categorised into medication errors, skills and conduct, safety/incident, quality of care and communication breakdown. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no external complaints received since the previous audit.</p>
Standard 1.1.9: Communication  Service providers	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's 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 in residents' records reviewed. There was evidence of resident/family</p>



communicate effectively with consumers and provide an environment conducive to effective communication.		<p>input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the Taranaki district health board (TDHB), Māori Health Advisors and when needed by family members and/or staff for whom English is not their first language.</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>Heritage Lifecare Limited (HLL) is responsible for the services provided. A business plan 2020 signed off by the regional operations manager was reviewed and includes a mission statement, philosophy, scope, objectives, values, and goals. Annual and longer-term objectives and the associated operational plans were sighted. The mission statement and philosophy of the organisation is also displayed at the entrance to the facility. The business plan is currently being reviewed for 2021 and will be redeveloped and implemented for March 2021. The CH &amp; VM is responsible for the day to day management of Annie Brydon Lifecare and reports to the regional quality manager and the regional operations manager. The CH &amp; VM demonstrated a sound knowledge on all aspects of the service provided including the monitoring of performance.</p> <p>The CH &amp; VM has been in their current position for three years and prior to this appointment had managed other aged care facilities for 19 years. The management of clinical services is the responsibility of the clinical services manager (CSM) who has been in this role for approximately two years. The unit coordinator a senior registered nurse was available to assist in the absence of the CSM for this audit. The CH &amp; VM and CSM have completed relevant education for their roles. The CSM has a current practising certificate.</p> <p>Occupancy on the first day of the audit consisted of 69 residents, 51 rest home level care (inclusive of one respite care resident) and 18 hospital level care (inclusive of one palliative care resident under an agreement with hospice). The TDHB are fully informed of this 42 day stay agreement for this one resident. There are 56 dual beds at this facility.</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</p>	FA	<p>A quality and risk management plan guides the quality programme that reflects the principles of continuous quality improvement.</p> <p>Quality, health and safety, restraint and infection prevention and control combined staff meetings and separate RN meetings are held monthly. Staff meetings include topics of interest. Meeting minutes including quality data are available in the nurses' station for staff to read. Meeting minutes evidenced reporting of completed internal audits, comprehensive quality data, including clinical indicators which are graphed. The CH &amp; VM is experienced in quality and risk management processes and is responsible for ensuring the organisation's quality and risk management systems are maintained and outcomes are reported monthly to support office.</p> <p>Clinical indicators and quality improvement data are recorded on various registers and forms and were reviewed.</p>

<p>continuous quality improvement principles.</p>		<p>There was documented evidence that quality improvement data is being collected, collated, comprehensively analysed and reported. Quality improvement data reviewed included adverse event forms, internal audits, meeting minutes, and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly from support office. A policy for document update reviews and document control policy was sighted. The office administrator is responsible for replacing the policies and procedures in the documentation control system. Staff confirmed they are advised of updated policies and that they provide appropriate guidance for service delivery.</p> <p>Annual surveys are completed by support office covering residents, family and staff. Feedback is provided to the CH &amp; VM for service quality improvement if required.</p> <p>Actual and potential risks are identified associated with human resources management, legislative compliance, contractual and clinical risk. The hazard register identifies hazards and evidenced the actions put in place to isolate or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The CSM and the unit coordinator are responsible for hazards management. The CH &amp; VM demonstrated a sound understanding of health and safety requirements in the absence of the CSM and was familiar with the Health and Safety at Work Act (2015) and the implemented requirements. Staff confirmed they understood and implemented documented hazard identification processes.</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</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form including neurological observations and falls risk assessments following accidents/incidents as appropriate. All clinical incident/accident forms are collated by the CSM. A copy is kept in the electronic resident records. The CH &amp; VM is responsible for non-clinical events. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. The satisfaction surveys confirmed this.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The CH &amp; VM advised there has been two essential notification made to the Ministry of Health since the previous audit.</p>

manner.		There are no known legislative or compliance issues impacting on the service.
<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>Policies and procedures relating to human resources management are in place. Staff files reviewed included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>The implementation of the organisation's education programme is the responsibility of the CH &amp; VM and is a strength of the service. In-service education is provided for staff using several mechanisms, including at least monthly sessions, on-line learning, toolbox sessions at handover, specific topics relating to resident's health status and staff meetings. The local DHB also provides an education programme for both managers and registered nurses (RNs) and enrolled nurses (ENs). Individual records of education are held on staff individual files and electronically. The office administrator maintains the records. Competencies were current including medicines, restraint, manual handling, fire safety and personal cares. Attendance records are maintained. Education sessions are evaluated by the CSM and any corrective actions developed and implemented. Three of 10 RNs are interRAI trained and have current competencies, including the CSM.</p> <p>The maintenance coordinator, the enrolled and registered nurses and three activities staff have all completed relevant first aid training.</p> <p>A New Zealand Qualification Authority education programme is available for staff to complete and they are encouraged to do so. The assessor for training is a registered nurse from another service who is responsible for care staff education for three facilities in this region. Training records are maintained. There are 35 support workers employed. Currently six care staff are in training for level 3, level three completed (10) and level four (4). Four staff have been offered the education and are yet to be enrolled. Eleven (11) staff are not completing any levels currently but have completed all competency requirements. The three cleaners and two laundry staff have completed level 2.</p> <p>An orientation/induction programme is in place and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to a month to complete and staff performance is reviewed at 12 weeks and annually thereafter. Orientation for staff covers all essential components of the service provided.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>

<p><b>Standard 1.2.8: Service Provider Availability</b></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 an HLL rationale for determining staffing levels and skill mixes to provide safe service delivery. The CH &amp; VM and CSM are responsible for the staff coverage of the facility. The CH &amp; VM interviewed stated that consideration of dependency levels of residents and the physical environment is taken into account. There are three service areas by design within the facility to be adequately covered. The rosters evidenced appropriate staff coverage in all service areas with 'runner' caregivers who move between services when the daily demands are determined by the CSM or unit coordinator. There are dedicated cleaners and laundry staff. The maintenance coordinator of the building is responsible for all maintenance and a grounds person for the gardens is available. Three recreational staff cover the activities programme for residents. The after-hours is covered by the CSM and senior registered nurses. Bureau staff have not been used at this facility for the last three years due to stable core staff.</p> <p>Rosters were reviewed and confirmed that staff cover was provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) registered nurse coverage. Care staff interviewed reported there is adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. A discussion with the RN administering the medication on the day of audit, identified that, at times, the two people checking the controlled drug medication, do not go to the bedside. A random sampling of pages in the controlled drug book identified an error and these areas require attention. A random control drug count verified accuracy.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the</p>

		<p>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 GP review is consistently recorded on the electronic medicine chart.</p> <p>There was one resident who was self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner.</p> <p>Medication errors are reported to the RN and clinical services manager (CSM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used at Annie Brydon.</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 service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed by a qualified dietitian 15 January 2021. Recommendations made at that time have been implemented.</p> <p>An up-to-date food control plan is in place at Annie Brydon, issued by the South Taranaki District Council on 23 December 2020, due to expire 23 February 2022.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are two dining rooms at Annie Brydon and there were sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p>
Standard 1.3.6:	FA	Except for that referred to in criterion 1.3.3.4, documentation, observations, and interviews verified the care

<p>Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>provided to residents at Annie Brydon 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 of a high standard. Care staff confirmed that care was provided as outlined at handover and as directed by the RN. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a diversional therapist and a recreation co-ordinator five days a week.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. The organisation's support office provides monthly themes for the activity programme, with a range of ideas. This is used in conjunction with activity assessments and resident input to formulate a programme that is meaningful to the residents. Activities assessments are regularly reviewed and evaluated as part of the formal care plan review every six months.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included crafts, visiting entertainers, quiz sessions, movie sessions, van outings, games, yoga, walks and daily news updates. The activities programme is discussed at the residents' and family meetings and minutes indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short-term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A building systems status report has been issued in lieu of a BWOFF (form 12). A BWOFF was unable to be supplied and displayed due to Covid-19 alert level restrictions preventing one or more scheduled inspections/maintenance procedures of the compliance schedule from being carried out. All specified systems in the building are currently performing to the performance standards stated in the building's compliance schedule. The premises compliance expiry date from Fire Security Services is 15 October 2021 and this is displayed in the entrance to the facility.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance of infections at Annie Brydon is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control officer who is the CSM, reviews all reported infections. Monthly surveillance data is entered into the organisation's electronic infection data base and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality/RN and staff meetings and at staff handovers. Graphs are produced that identify trends for the current year and comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>A good supply of personal protective equipment is available. Annie Brydon has processes in place to manage the risks imposed by Covid-19.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 restraint coordinator, a registered nurse, provides support and oversight for enabler and restraint management in the facility and a job description was reviewed.</p> <p>On the day of the audit, no residents were using a restraint. Three residents were using enablers, which were the least restrictive and use voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. The enabler register was reviewed.</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)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation,</p>	<p>PA</p> <p>Moderate</p>	<p>Discussion with an RN identified that occasionally at lunchtimes, when everyone is busy, the two people checking controlled drugs do not go to the resident's bedside and therefore cannot verify the correct drug is administered to the correct resident. A random check of the controlled drug register identified a discrepancy in the liquid dose remaining. On querying this with an RN, it was identified when any liquid controlled drug is no longer required it is witnessed and tipped down the sink. The discrepancy in the controlled drug register was because an amount had not been recorded as 'discarded'. Further discussion identified this practice has been long standing.</p> <p>A further random review of controlled medications (pills) found accurate records for those medications.</p>	<p>The process of managing controlled drugs at Annie Brydon does not ensure the correct resident is getting the correct medication. The discarding of controlled drugs at Annie Brydon is not occurring as per safe practice guidelines and in accordance with legislative requirements.</p>	<p>Provide evidence that controlled drugs no longer required are managed as per legislative requirements. Provide evidence that staff who check controlled drugs ensure the drug is administered to the correct resident.</p>



protocols, and guidelines.				30 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA</p> <p>Moderate</p>	<p>Five of eight residents' care plans did not include documentation that described fully the residents' required clinical needs. The areas of need specifically related to special precautions in managing a wound, acknowledging a chronic respiratory condition and required management strategies, the presence of a pressure injury, acknowledging the presence of an indwelling catheter, and management plan, a deteriorating resident with no update to the care plan, the absence of a pain, dietary and skin assessment, plus associated management plans, including daily blood sugar monitoring. Evidence was sighted of residents' care in attending to these needs being met. The unit coordinator agreed with the finding and identified this was due to the recent recruitment of new and inexperienced RNs. The regional quality manager agreed with the finding, as it matched the findings of a recent in-house audit.</p>	<p>The documentation in the care plans of several residents reviewed at Annie Brydon did not fully describe the care the residents' needs to enable continuity and promote a team approach.</p>	<p>Provide evidence residents' care is documented to enable a coordinated approach and ensure continuity of care.</p> <p>90 days</p>

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

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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.

No data to display
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End of the report.