

# TerraNova Homes & Care Limited - Brittany Residential Care

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## Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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:** TerraNova Homes & Care Limited

**Premises audited:** Brittany House Residential Care

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

**Dates of audit:** Start date: 8 June 2021 End date: 9 June 2021

**Proposed changes to current services (if any):** The wings have been renamed in the past, and on the day of audit, it was difficult to identify which rooms were two or three bedded rooms that had been certified in the past (noting that there have been renovations as identified in previous audit reports, which showed changes from four to three or two bedded rooms). To clarify this, the audit confirmed that there are now five two-bed rooms (rooms 1, 42, 43, 50 and 53 with 53 changed from a lounge to a two

bedder room prior to the audit). There are also two three-bedder rooms (44, and 45). The audit verified the appropriateness of these rooms to provide care for the number of residents identified in each room.

**Total beds occupied across all premises included in the audit on the first day of the audit: 56**

# 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

TerraNova Homes & Care Limited - Brittany Residential Care (referred to as Brittany House is a standalone facility). The service provides care for up to 62 residents. The service is certified to provide hospital (medical and geriatric) rest home and residential – disability physical level care. On the day of the audit, there were 56 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff, management, and general practitioner.

Brittany House has a documented quality and risk management programme. The owner has invested in technological advancement since the last audit including implementation of a new clinical management system and cordless call bell system; have refurbished the ground floor public areas including conversion of the chapel to the residents’ “Hub”; and has expanded the activities programme with the inclusion of virtual programmes.

This audit identified improvements required around visual privacy for residents, informed consent, the quality programme, orientation and training, care planning and interventions, food services and hot water temperatures.

A rating of continuous improvement has been awarded around the activities programme.

## Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Policies are documented to support resident rights and residents stated that their rights are upheld. Individual care plans include reference to residents' values and beliefs. Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained. Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

## Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service has support from the owner and operational management is provided by the facility manager who started in the role in September 2020. The facility manager has experience in managing other services and is supported by the clinical manager who has 25 years' experience as a registered nurse with two of these being in aged care.

There is a documented quality and risk management programme with key components of the system including management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, and review of risk and monitoring of health and safety, including hazards. Quality data is discussed at facility meetings.

Human resource policies are in place, including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate staff coverage for the effective delivery of care. An orientation and training programme is documented. Registered nursing cover is provided 24 hours a day, 7 days a week.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six- monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent caregivers responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The activities coordinator implements the activity programme to meet the individual needs, preferences, and abilities of the residents. This includes the provision of a range of activities for younger disabled residents, including education, leisure, and cultural events as part of a plan developed in partnership with the resident. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system.

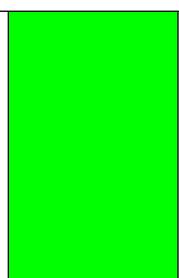
Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme.

## 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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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint standards are being implemented and implementation is reviewed through internal audits, and facility meetings. Interviews with the staff confirmed their understanding of restraints and enablers. On the day of audit, the service had no restraints in use and three residents with an enabler.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control resource nurse (clinical manager) is responsible for coordinating education and training for staff. The resource nurse has completed annual training through an online provider in addition to ongoing Covid-19 education

provided by the local DHB. There is a suite of infection control policies and guidelines to support practice. The infection control resource nurse and facility manager use the information obtained through surveillance to determine infection control activities and education needs within the facility.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	1	35	0	5	4	0	0
<b>Criteria</b>	1	80	0	8	4	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in visible locations. Policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training (link 1.2.7.5).</p> <p>Interviews with managers (the facility manager and clinical manager), and staff (three caregivers, two registered nurses, physiotherapist, two activity coordinators, one kitchen manager, one maintenance, two laundry and one clinical coordinator), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Low	<p>There is an informed consent policy, however in eight files reviewed, (five hospital and three rest home residents), not all residents had general consent forms signed on file. Care staff were knowledgeable around informed consent. Residents and relatives interviewed could describe what informed consent was and knew they had the right to choose. There is an advance directive policy.</p> <p>There was evidence in files reviewed of family/EPOA discussion with the GP for a medically</p>

		<p>indicated not for resuscitation status. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files seen. Copies of EPOAs were on resident files where available.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends, and community groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident meetings are held monthly. The service works with their YPD residents to encourage continued involvement with community groups.</p> <p>Many of the hospital residents have high physical needs, so often it is more appropriate to support family, friends, and community groups to come into the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives on entry to the service. Discussions with residents and relatives confirmed they were provided with information on complaints. Complaints forms are in a visible location at the entrance to the facility.</p> <p>The facility manager maintains a record of all complaints, both verbal and written. Four complaints were received in 2020 and three in 2021 year to date. Three complaints were reviewed, and all included evidence of appropriate follow-up actions taken. Caregivers interviewed commented that complaints are part of the meeting agenda and are discussed at various facility meetings with this sighted in meeting minutes reviewed.</p> <p>The Ministry requested follow-up against aspects of a complaint that included service provider availability and the call bell system. There were no identified issues in respect of this complaint. A response was received by the service from HDC which confirmed there were no</p>

		further actions required and the case was closed.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The facility manager, the clinical manager, clinical coordinator, and registered nurses discuss aspects of the Code with residents and their family on admission.</p> <p>Discussions relating to the Code are held during the resident/family meetings. All 15 residents (12 rest home level including one under an ACC contract, and three hospital level residents including one young person with a disability [YPD]), and two relatives (one rest home and one hospital) interviewed, reported that the residents' rights are being upheld by the service. There were no complaints around physical privacy.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	PA Low	<p>Residents are treated with dignity and respect. Independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Staff knock on resident doors prior to entering with this occurring in practice during the audit. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans.</p> <p>Resident files sampled documented that cultural and/or spiritual values and individual preferences are identified on admission and these are integrated into the resident's care plan. Interviews with residents confirmed that their values and beliefs are considered.</p> <p>There is a policy around abuse and neglect. Staff receive training around abuse and neglect. Staff, managers, external providers, and the general practitioner interviewed confirmed that there is no evidence of any abuse or neglect.</p> <p>There are some shared bedrooms. All shared rooms have curtains between bed spaces to protect resident's privacy and dignity. Residents give consent to share rooms. There are two communal shower/toilet blocks that potentially do not afford privacy for residents using them at all times.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The activities programme is based on Te Whare Tapa Whā model of service delivery. There are nine</p>

<p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>		<p>residents who identify as Māori and that has been recognised in the activities programme. There are 10 staff who identify as Māori with seven able to speak te reo Māori fluently. Residents who spoke te reo Māori were seen to be conversing with staff who could also speak te reo Māori.</p> <p>Māori consultation is available through the documented iwi links and Māori health services. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. There are guidelines for understanding the Māori culture as it relates to health. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents and staff value and encourage active participation and input of the family/whānau in the day-to-day care of the resident.</p> <p>The residents welcomed the audit team with a powhiri ceremony on the first day of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed, and they are incorporated into the residents' electronic care plans. All residents and relatives interviewed confirmed they were involved in developing the resident plans of care, which included the identification of individual values and beliefs. There are spiritual, religious, and cultural standard operating procedures (SOPs) to guide staff. All care plans reviewed included the resident's social, spiritual, cultural, and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff described implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment, and exploitation. Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed stated that they were aware of the policies and were active in identifying any issues that relate to the policy.</p> <p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the staff files sampled. Staff comply with confidentiality and the code of conduct. The employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Monthly staff meetings include discussions on professional boundaries and concerns as they arise (minutes sighted).</p> <p>Residents and the family members interviewed stated that they would formally complain to management if they felt that they were discriminated against. There were no complaints</p>

		recorded in the complaints register for the previous 12 months relating to any form of discrimination or exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The service promotes evidence-based practice and encourages good practice. Registered nursing staff are available 24 hours a day. A house GP visits the facility at least once per week. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable.</p> <p>The service receives support from the district health board, which includes visits from the mental health team and nurse specialist visits. Physiotherapy services are provided on site for eight hours per week with the support of a physiotherapy assistant. The service has links with the local community and encourages residents to remain independent. The manager advised that there are relationships with the local hospice who provide training and support.</p> <p>Facility meetings occur regularly (as sighted). Staff are kept informed on all facility and clinical matters. Residents and family interviewed stated that they are kept well informed around Covid-19. Discussions with residents and family were positive about the care they receive. The general practitioner (GP) praised the service for care provided.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	<p>Standard operating procedures relating to accident/incidents, complaints, and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is an open disclosure policy. Not all family were notified in the event of an incident. Relatives interviewed reported that they are contacted when there is a change to treatment of care, or if there has been an incident.</p> <p>Interpreting services are available, however there were no residents requiring use of an interpreter. Staff were employed who could converse in te reo Māori if that were required. Staff could describe how interpreter services can be accessed. The information pack is available in large print and read to residents who require assistance.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</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>Brittany House provides care for up to 62 residents. The service is certified to provide hospital (medical and geriatric), rest home level care and residential disability – physical level care. On the day of the audit, there were 56 residents. There were 20 residents using hospital level of care (including two YPD residents with physical disabilities, one under an ‘engaged contract’, and with the service for up to six weeks, one resident under an ACC contract). There were 36 residents requiring rest home level of care (including one YPD resident with physical disabilities, one resident under an ACC contract, and one resident under a mental health contract).</p> <p>The wings have been renamed in the past, and on the day of audit, it was difficult to identify which rooms were two or three bedded rooms that had been certified in the past (noting that there have been renovations as identified in previous audit reports, which showed changes from four to three or two bedded rooms). To clarify this, the audit confirmed that there are now three two-bedded rooms (rooms 1, 42 and 53 with 53 changed from a lounge to a two-bedded room prior to the audit). There are also three three-bedded rooms (43, 44, and 45). The audit verified the appropriateness of these rooms to provide care for the number of residents identified in each room.</p> <p>The organisation has a vision, mission statement and objectives. There is an organisational business plan that links to the site-specific quality goals and objectives. The business plan for 2020 was reviewed prior to the development of the business plan 2021. The facility manager gives a verbal report to the owner weekly with monthly reporting also completed.</p> <p>The facility manager is non-clinical with a postgraduate diploma in business and leadership training. The facility manager (FM) has been a paramedic and has 25 years’ experience in management roles. The FM was appointed into the position in September 2020. The FM are supported by a clinical manager who started in the role in December 2020. The clinical manager has 25 years’ experience as a registered nurse with two years’ experience in aged care. They have also worked overseas in rehabilitation for aged care. Staff spoke positively about the support/direction and management of the current management team.</p> <p>The facility manager and clinical manager have maintained over eight hours annually of professional development activities related to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which</p>	<p>FA</p>	<p>A clinical coordinator/registered nurse (RN) who is employed full-time, supports the clinical and facility managers and they step in when the facility or clinical manager is absent.</p>

<p>ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>A quality and risk management programme is well established. Interviews with the managers and staff reflected their understanding of the quality and risk management systems.</p> <p>TerraNova’s policies, procedures and relevant forms are available both in hard copy and online under “Share Point” (intranet). Review of clinical policies and procedures is coordinated by the clinical quality and risk advisor (CQRA) in conjunction with the managers and clinical coordinators. Approval of the amended/new document involves the executive management team before uploading and release of the document.</p> <p>Updated documents are released/supplied to the facility. A memo is sent to the managers along with printed copies of relevant documents for filing in their master hard copy folders. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): resident falls; infection rates; complaints received; restraint use; pressure injuries; wounds; and medication errors. An annual internal audit schedule was sighted for the service, with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including trends in data and benchmarked results are discussed in staff meetings. Corrective actions are implemented when service shortfalls are identified and signed off when completed.</p> <p>A residents meeting occurs two monthly and an annual resident survey is completed. The last survey identified 96% overall satisfaction with the service. Quality projects were implemented as a result of suggestions from the resident’s meetings (link to 1.3.7.1).</p> <p>Interviews with staff and review of meeting minutes/quality corrective action forms/opportunist education sessions, demonstrated a culture of quality improvements.</p> <p>Falls prevention strategies are in place. A health and safety system is in place. Health and safety is an agenda item of the staff meeting. Hazard identification forms and a hazard register are in place. Health and safety management has been improved with organisational three-monthly health and safety meetings, the appointment of a health and safety officer and representative and a focus on reducing hazards and promoting safe work habits amongst employees.</p> <p>A robust risk management system is in place with the clinical coordinator completing a</p>

		<p>monthly report with corrective actions. Incident management is well managed, with all incidents being reported on 'eCase' and reviewed by the clinical coordinator and facility manager (FM) on a daily basis. Incidents are also able to be reviewed in detail by the CEO and CQ&amp;R advisor on 'eCase'.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b> All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects incident and accident data and manually collates this information for analysis. Monthly and annual reports are produced, which are then discussed at the staff meetings.</p> <p>There were 15 resident-related incident forms reviewed. All incident forms (three absconding, one incidence of choking, and eleven unwitnessed falls) identified a timely RN assessment of the resident and corrective actions to minimise resident risk and reoccurrence, however neurological observations were not completed for all unwitnessed falls according to policy (link 1.3.6.1). The caregivers and registered nurses interviewed could accurately relate the incident reporting process. The clinical manager investigates and signs off on all incident reports. Family were not always notified when an incident had occurred (link 1.1.9.1).</p> <p>The clinical manager and facility manager interviewed could describe situations that would require reporting to relevant authorities. The Ministry of Health were notified appropriately for two changes in management since the last audit and there has been one Section 31 notification for an unstageable pressure injury.</p>
<p><b>Standard 1.2.7: Human Resource Management</b> Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files reviewed (facility manager, clinical manager, two RNs, two caregivers, one clinical coordinator, and one activity coordinator) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates is maintained.</p> <p>The service has a comprehensive orientation programme in place that is expected to provide new staff with relevant information for safe work practice. Not all staff had an orientation form completed. New staff interviewed stated that they were buddied for a period of time and during this period they do not carry a clinical load.</p> <p>The 2020 and 2021 education plans were sighted. While training is offered, there are only a few staff who attend. A competency programme is in place with different requirements according to work type. Core competencies are completed annually, and a record of completion is maintained. In the past, here has been a focus on ensuring that caregivers</p>

		complete Careerforce. While the service was unable on the day of audit to confirm numbers of caregivers at different levels, it was noted that the three caregivers interviewed had all completed level four. There are six RNs and four have completed interRAI training.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing levels meet contractual requirements. The facility manager, clinical manager, and clinical coordinator are available during weekdays and on call out of hours.</p> <p>Ground floor: There are two wings as follows: Mohaka with nine residents at rest home level of care and Tukituki with 15 residents at rest home level of care. There are two caregivers on duty in the morning including an enrolled nurse or senior caregiver and one other caregiver; two caregivers in the afternoon including one on a short shift; and one caregiver overnight. A registered nurse is allocated to complete at least four hours a week on the ground floor. Young people with disabilities are placed in wings according to their needs and where there are other young people.</p> <p>Upstairs: There is a registered nurse on duty on each shift with the clinical coordinator on day duties during the week. There are four wings upstairs as follows: Wairua with two rest home residents and six hospital; Clive with six rest home residents and six hospital; Tima with one rest home resident and five hospital; Shine with three rest home and three hospital residents. The following staff are allocated to the upstairs wings: five caregivers in the morning (three full shift; two from 7 am to 6 pm) and one staff from 10 am to 6 pm (a new shift recently put in place to support acuity of residents). In the afternoon, there are six caregivers (two from 3 pm to 11 pm; one from 3 am to 10 pm; one from 3 pm to 10.30 pm; one from 4 pm to 8 pm. There is one caregiver overnight.</p> <p>The rosters reviewed evidenced an increase in staffing with an increase in occupancy and vice versa.</p> <p>Staff, family members and residents interviewed reported that there were enough staff on duty to meet resident needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. All staff have access to areas relevant to them on the electronic system. Electronic records are protected from unauthorised access. Hard copy records are held securely.</p>

		Residents' files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation. Electronic records clearly identify staff member and time.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is an implemented organisational admission policy. All residents have a needs assessment completed prior to entry that identifies the level of care required. The facility manager and clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>An information pack including all relevant aspects of the service, advocacy and health and disability information is given to residents/families/whānau at entry. All relatives interviewed were familiar with the contents of the pack. The admission agreement provides information on services which are excluded, and examples of how services can be accessed that are not included in the agreement. Short-stay agreements are also available for short-stay residents; there was one short-stay resident at the time of audit.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission in to the facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit. No standing orders are used, and no vaccines are stored on site.</p> <p>The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses, enrolled nurses and medication competent caregivers administer medications, have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperatures are checked daily</p>

		<p>and are within the required ranges. Eye drops viewed in medication trolleys had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Sixteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</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>PA Moderate</p>	<p>Residents stated that they are provided with a diet, which meets their cultural and nutritional requirements. The meals are cooked on site in a well-equipped kitchen. Residents interviewed reported they are satisfied with the service. Resident meetings discuss food, and feedback is given.</p> <p>There is a four-weekly seasonal menu which has not recently been reviewed by a registered dietitian (last reviewed 2017). A dietitian visits as required. A dietary assessment is completed on all residents at the time they are admitted, however these were not current. Resource information on special diets is available in the kitchen. Special equipment is available such as lipped plates. Lunch meals were observed. Staff were observed assisting residents with meals. The kitchen was observed to be clean and well organised, however there were identified shortfalls around fridge and freezer monitoring.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The reason for declining service entry to potential residents should this occur, is communicated to the potential resident or family/whānau and they are referred to the original referral agent for further information. The reasons for declining entry would be if the service had no beds available or could not provide the level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed (with exception of the ACC resident). Six monthly interRAI assessments and reviews are evident for five of eight resident files sampled as one hospital resident was under a short-term care contract, one new admission and one on an ACC contract.</p>

		Resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For four of eight resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans (link 1.3.5.2).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans reviewed were resident centred. Interventions documented support needs and provided detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the diabetic specialist nurse, dietitian, wound care specialist and occupational therapist. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents occurs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans are updated as residents' needs changed.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The nursing staff were aware of residents' dietary requirements and these could be seen documented and were easily accessible on the electronic resident management system, however these needs were not always communicated effectively to staff in the kitchen (link 1.3.13.1).</p> <p>There was evidence of wound nurse specialist involvement in chronic wounds/pressure injuries. There were 15 ongoing wounds including skin tears, surgical wound, and chronic ulcers. There was one unstageable DHB acquired pressure injury. All wounds had wound assessments, appropriate management plans and ongoing evaluations completed.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs, FBCs, turning charts, wounds and neurological observations. However, these have not always been fully completed.</p>

<p><b>Standard 1.3.7: Planned Activities</b></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>	<p>CI</p>	<p>The service employs two activities coordinators covering Monday to Friday between them, who plan and lead the activities in the home. This is done in conjunction with a resident activities committee, named the 'whānau support team'. Activities at the weekends are led by a team of volunteers which also includes residents.</p> <p>There are set activities including themes and events which the activities team add to in order to individualise activities to resident need and preferences. A weekly activities calendar is distributed to residents, posted on noticeboards and is available in large print. On the days of audit residents were observed participating in activities, including a group powhiri to welcome the audit team on site. The activity coordinators seek verbal feedback on activities from residents and families to evaluate the effectiveness of the activity programme, enabling further adaptation if required. Residents interviewed were positive about the activity programme.</p> <p>Residents under 65 years of age have YPD specific activities plans that reflect differing needs and provide tailored, age-appropriate activities.</p> <p>Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. There are weekly outings to places chosen by the residents and there are regular entertainers visiting the facility. Residents also share their talents and provide entertainment themselves as witnessed at the time of audit.</p> <p>Special events like birthdays, Easter, Mothers' Day, Anzac Day, and other cultural festive days are celebrated. There are visiting community groups such as local church groups, pet therapy and visiting schools. The activity team provides a range of activities which include (but are not limited to) exercises, walks outside, crafts, games, quizzes, entertainers, gardening, and bingo.</p> <p>The activity team are involved in the admission process, completing the initial activities assessment, and have input in to the cultural assessment. An activities plan is completed within timeframes, a monthly record of attendance is maintained, and evaluations are completed six-monthly.</p> <p>Those residents who prefer to not to participate in communal activities receive one-on-one visits and individualised activities such as pampering sessions according to their preferences.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are</p>	<p>FA</p>	<p>Long term care plans are evaluated by the RNs six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six-monthly care plan review is also completed by the registered nurse with input from</p>

<p>evaluated in a comprehensive and timely manner.</p>		<p>caregivers, the GP, the activities coordinator, resident (if appropriate) and family/whānau members and any other relevant person involved in the care of the resident.</p> <p>Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The clinical manager and registered nurses interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the clinical manager and registered nurses identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</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>PA Low</p>	<p>The building holds a current building systems status report issued in lieu of a building warrant of fitness due to Covid-19 alert level restrictions preventing one or more required components to be signed off. This expires 25 January 2022.</p> <p>There are two lifts and stair access between the two floors. Both lifts can accommodate a bed/ambulance stretcher. The ground floor has two resident wings (Tukituki and Mohaka), and there are two double rooms, both in Mohaka wing, one in Tukituki, and all other rooms are single. On the upper floor, there are four resident wings (Te Ana, Wairoa, Clive, and Shine). Clive wing has two, three-bedded rooms, while Wairoa wing has two double rooms and one, three-bedded room. Room 53 was previously a lounge which has been reconfigured into a double room. All multiple occupancy rooms are large, have privacy curtains and utilise the</p>

		<p>wireless call bell system for resident safety.</p> <p>There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs and is undertaken by the full-time maintenance officer. The maintenance officer provides an on-call service out of hours and essential contractors are available 24-hours.</p> <p>Electrical equipment has been tested and tagged, expiring September 2021. The hoist and scales are checked annually and are next due to be checked November 2021. Hot water temperatures have been monitored in resident areas and are being dealt with as part of a corrective action plan currently.</p> <p>Flooring is safe and appropriate for residential care. The facility has wide corridors with safety rails that facilitate safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas are well maintained and have attractive features, including wheelchair friendly garden beds and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p> <p>Care staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All residents' rooms on the lower floor have ensuites. On the upper floor, Shine and Te Ana wing rooms have ensuites, while Wairoa and Clive wing rooms share communal facilities, of which there are a sufficient number to cater for resident need. Handrails are appropriately placed in ensuite bathrooms and communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuites. Communal toilet/shower/bathing facilities have a system that indicates if it is engaged or vacant, however not all communal showers/bathrooms adequately maintain resident privacy (link 1.1.3.1).</p> <p>Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to</p>	FA	<p>There are five double rooms, three three-bedded rooms and all other resident's rooms are single. The double and triple rooms have privacy curtains to provide resident privacy when required. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide</p>

the consumer group and setting.		care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large and small communal areas, with a dining room on each floor. The dining areas are homely, inviting, and appropriate for the needs of the residents. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The facility centres around 'The Hub', a large communal space utilised for entertainment, activities, and meetings. Residents interviewed commented about the light, airy feel of the hub and the large amount of space available for resident activities. All lounge/dining areas are accessible and accommodate the equipment required for residents. Residents are able to move freely and safely, and furniture is arranged to facilitate this.</p> <p>The communal space also includes a small café, a hair and beauty salon and a games area, including a pool table. Residents also have access to a scooter parking bay, physiotherapy room and gymnasium.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done on site. There are clearly defined clean and dirty areas. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms are kept locked when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months and there is a New Zealand Fire Service approved evacuation scheme.</p> <p>The orientation programme and annual education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies available in the event of a civil defence emergency including water, food, and supplies (torches, radio, and batteries), emergency power and a gas BBQ is available on the premises as an alternate cooking source. The facility keeps sufficient emergency water for 10 litres per person, per day for at least 3 days for resident use on site.</p>

		<p>There is emergency lighting.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells, with the majority or residents utilising a wireless system via a wristband pendant. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Residents were observed in their rooms with sensor mats in close proximity and were seen to be wearing wristband pendant alarms.</p> <p>There is always at least one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p> <p>Security policies and procedures are documented and implemented by staff. The buildings are secure at night and the doorbell is linked to the call bell system. There are external sensor lights around the building and a security patrol regularly checks the facility overnight.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The clinical manager fulfils the role infection control resource nurse and has done for the past six months. Responsibility for infection control is described in the job description which was evidenced on the day of audit. The resource nurse oversees infection control for the facility, reviews incidents, and is responsible for the collation of monthly infection events and reports. The infection control programme is reviewed annually by the facility management team. The resource nurse, clinical coordinator and facility manager meet monthly to analyse and discuss infection trends within the facility and formulate corrective action plans if required.</p> <p>The facility has a Covid/Pandemic plan in place and appropriate amounts of PPE on hand to last for at least two weeks in case of a further lockdown. During Covid the service held regular virtual meetings with the DHB Covid preparedness team to check policies, procedures, and service readiness. As part of the pandemic response the service implemented mandatory staff handwashing on entry to the facility, and although this is no longer mandatory, staff are strongly encouraged to continue this practice.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility and Covid scanning and/or manual sign in is mandatory. Residents are offered the</p>

		annual influenza vaccine. There have been no outbreaks in the previous year.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Brittany House. The infection control resource nurse liaises with the facility management team who meet monthly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The infection control resource nurse has not yet completed external training in infection control (link 1.2.7.5).</p> <p>External resources and support are available through external specialists, microbiologist, GP, wound nurse and DHB when required. The GP monitors the use of antibiotics. Overall effectiveness of the programme is monitored by the infection control resource nurse, clinical coordinator, and facility manager.</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 control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection; and training and education of staff (link 1.2.7.5). Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by a contracted consultant and adapted by the site with input from the DHB infection control specialist.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control resource nurse is responsible for coordinating education and ensuring staff attend infection control in-services and updates. Training on infection control is included in the orientation programme (link 1.2.7.4). Staff have had infection control education available in the last 12 months (link 1.2.7.5).</p> <p>The resource nurse has also completed infection control audits (link 1.2.3.8). Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
Standard 3.5: Surveillance	FA	Surveillance is an integral part of the infection control programme and is described in the

<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>facility's infection control manual. The infection control resource nurse collates the information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trend analysis is discussed with the facility manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Results from laboratory tests are available as required. There have been no outbreaks since the previous audit.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint minimisation policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.2. The policy includes restraint/enabler management procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings and restraint steering meetings at an organisational level. Interviews with the staff confirmed their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had no restraint in use. Three residents had bedrails as an enabler with one resident also having a chest harness when in a wheelchair. All enabler use is voluntary. Two resident files were reviewed where an enabler was in use. The enabler assessment form was completed and signed by both residents. The assessment/evaluation form has been evaluated at least three-monthly. The residents had given consent for the devices to be used. Both residents also had checks while the enabler was in use.</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)
Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.	PA Low	Signed informed consents were evident on six out of eight files sampled. Two out of eight of these files did not have a signed consent.	Two (hospital including one respite) out of eight resident files reviewed did not have a signed consent.	Ensure all residents have given informed consent.  90 days
Criterion 1.1.3.1 The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.	PA Low	The privacy policy has been reviewed with reference to the Privacy Act 2020. Staff interviewed were able to describe how they maintained privacy for residents during showers, toileting and when private conversations were held. There are two shower/toilet rooms (both have two showers with curtains and one toilet with a separate door). The door to the hallway has a panel with frosted glass however the silhouette of the person inside of the room can be seen. The resident satisfaction survey completed in May 2021 identified issues related to privacy in general noting that the communal showers were not specifically	There are two communal shower/toilet blocks that potentially do not afford privacy for residents using them at all times.	Ensure that communal shower/toilet blocks allow for privacy for residents using them at all times.

		identified. There have not been any complaints specially related to lack of privacy while using communal showers/toilets.		90 days
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	There is an open disclosure policy. Not all family were notified in the event of an incident. Relatives interviewed reported that they are contacted when there is a change to treatment of care, or if there has been an incident,	Six of fifteen incident reports did not evidence family contact following the incident being reported.	<p>Ensure that family are contacted in a timely manner to inform them of the incident</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Moderate	<p>There are processes documented to ensure that any recommendations or gaps identified in audits or meeting minutes are resolved in a timely manner. Corrective action plans were not fully documented when issues were raised in audits or closed out when issues were identified in meetings. The resident/family satisfaction survey had been completed in May 2021 with 29 returns. Data has been collated, however there is no corrective action plan developed and implemented to improve areas related to privacy, food services, and to knowledge of The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>A review of food services showed that corrective actions related to the previous MPI audit had not been addressed.</p>	Corrective action plans are not documented when issues are raised in audit reports, food service audits, or satisfaction surveys or documented with evidence of resolution, and issues are not closed out when these are raised in meetings.	<p>Ensure that there are corrective action plans documented when issues are raised in audit reports and evidence of resolution of issues against corrective actions when addressed including those raised in meetings.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an</p>	PA Low	Eight staff records were reviewed. Five were for staff who had been appointed in 2021. Overall, there were three of the eight staff records reviewed that had documentation confirming that an orientation had been completed. Of the five new staff employed	Orientation is not documented as being completed in five or eight	Ensure that all staff have documentation in their staff file that

<p>orientation/induction programme that covers the essential components of the service provided.</p>		<p>in 2021, one of the five had an orientation completed as being documented. Two new caregivers interviewed stated that they had completed orientation that included an orientation to the service and residents, a buddy programme and reading of policies.</p>	<p>staff files reviewed.</p>	<p>confirms orientation has been completed.</p> <p>90 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>There is a training plan in place for 2021 with the 2020 plan also sighted. Completion of training for 2020 was not able to be sighted. Training has been offered in 2021 as per plan, however attendance numbers are low (between three and twelve generally except for website training, Covid-19 update and training, dementia, fire training). The service is moving to holding mandatory training days with these repeated throughout the year to ensure that all staff can access these. The plan is in place for mandatory training. Staff stated that they had training in 2020.</p> <p>The managers are newly appointed and have not been able to locate training records of caregiving staff who have completed Careerforce training. There are no staff enrolled in training currently. The infection control resource nurse has not yet completed annual training in infection control</p>	<p>(i) Training has not been accessed by a significant numbers of relevant staff in 2020 and 2021.</p> <p>(ii) Managers were not able to confirm numbers of caregiving staff who had completed Careerforce training.</p> <p>(iii) The infection control resource nurse has not yet completed annual training in infection control.</p>	<p>(i) Ensure that training is provided and attended by staff as per the training plan.</p> <p>(ii) Collate statistics around caregivers who have completed Careerforce training.</p> <p>(ii) Ensure that the infection control resource nurse completes annual training in infection control.</p> <p>180 days</p>
<p>Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional</p>	<p>PA Low</p>	<p>The menu has not been reviewed since March 2017. The menu has been changed with deserts now at midday (previously not included) and fresh fruit stated as being given at tea time. This was not previously on the menu. There are no vegetarian options on the menu although the kitchen manager could describe these with vegetarian sausages and patties available. There is one resident who is vegetarian. The resident stated that they got vegetarian meals, and this was observed to occur on the day of</p>	<p>The menu has not been updated since March 2017 and it currently does not reflect what is being provided.</p>	<p>Review the menu to ensure that it meets resident needs and reflects what is being provided.</p>

guidelines appropriate to the consumer group.		audit.		90 days
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Moderate	Dietary assessments are completed on entry to the service as part of the initial assessment, reviewed six monthly and updated as changes occur. The kitchen file does not include updated dietary requirement forms with some dating back to 2018. The kitchen manager stated that kitchen staff are not informed of any resident losing weight. The whiteboard includes any allergies or likes/dislikes. The kitchen staff interviewed stated that they assume these are correct.	Dietary assessments are not kept updated for kitchen staff to view and kitchen staff are not informed of residents who are losing weight.	Ensure that kitchen staff have accurate information around each resident's dietary needs.  60 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	The policy and food control plan confirm that fridge and freezer temperatures are to be taken daily with the normal range of temperatures documented. The form used to record fridge temperatures states that the temperature of the fridge should be between 2-8 degrees Celsius. The Food control plan states that the temperature should be 5 degrees Celsius or less. Temperatures recorded in the log identify these as ranging from 2 degrees Celsius to 10 degrees Celsius with no corrective actions in place. Temperatures for the freezers were also recorded as 20 degrees Celsius with the cook stating that these should be at 3 degrees Celsius. The temperature of one fridge has not been recorded at all.	(i) Fridge and freezer temperatures are not recorded accurately as per policy and the temperatures of one fridge are not being monitored.  (ii) Corrective actions are not put in place when temperatures are over the normal as per policy.	(i) Record fridge and freezer temperatures accurately including taking temperatures for one fridge where temperatures have not been previously monitored.  (ii) Develop corrective action plans when temperatures are not within normal range and sign off evidence of resolution.  90 days

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The RNs complete assessments to identify the care needs of the resident and use this information to inform the development of the care plan. Not all care plan interventions to support assessed care needs were documented in the long-term care plans in sufficient detail to guide the care staff. There is evidence of the use of short-term care plans, and these have been signed out or added to the long-term care plan, if not resolved.</p>	<p>(i) Four (three rest home, one hospital) of eight files sampled did not include interventions or interventions were not documented in sufficient detail to guide the care staff in the management of cellulitis, diabetic emergencies, enteral feeding and falls prevention.</p> <p>(ii) Two (hospital) of eight resident care plans sampled did not detail the need or rationale for the crushing of medication in line with the residents' medication charts.</p>	<p>(i) Ensure that care plan interventions are documented in sufficient detail to guide the care staff.</p> <p>(ii) Ensure that details around the need for, or rationale for the crushing of medication in line with the residents' medication charts is documented in care plans.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Interviews with the clinical manager and registered nurses demonstrated an understanding of the assessment, monitoring and management plans. Monitoring forms are used to monitor residents' health and well-being including blood pressure and pulse, weight, blood sugar levels, behaviour, repositioning, food, and fluid intake/output. However, these were not all fully completed. Short-term care plans sighted on the day of audit included wounds, skin tears and infections. These had been reviewed regularly and signed off when resolved or transferred to the long-term care plan.</p>	<p>(i) One hospital level resident for daily PEG Feed monitoring did not have monitoring documentation completed.</p> <p>(ii) One hospital resident with an identified pressure injury did not have the required repositioning consistently documented.</p> <p>(iii) Two hospital residents with catheters did not have daily fluid balance charts</p>	<p>(i)-(iii). Ensure resident monitoring charts are consistently and comprehensively completed. (iv). Ensure that neurological observations are recorded for unwitnessed falls as per policy.</p>

			<p>completed consistently.</p> <p>(iv). Eleven of eleven incident forms were sampled where the resident had experienced an unwitnessed fall. RN assessment was documented following the incident however, neurological observations were not completed as per policy</p>	60 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	<p>There are hazard management systems in place to ensure the physical environment minimises risk of harm, however hot water temperature has not been well controlled during the previous six-month period.</p>	<p>Hot water temperature has not been well controlled over previous six months, despite monthly water temperature testing they continue to be above 45 degrees. The service undertook an analysis of hot water issues and an action plan has been put in place. At the time of audit this action plan, which included a plumber, had just commenced.</p>	<p>Ensure that hot water temperature issues are addressed in a timely fashion.</p> <p>90 days</p>

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

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	<p>The approach implemented relating to activities is one of integration and a focus on ‘making a difference in the lives of fellow residents as a whānau is evident within the facility. Residents interviewed confirmed their input allowed the activities to be personalised and meaningful in terms of choice, engagement, and culture.</p> <p>The resident led activities, cultural activity programmes and events that have been implemented are supported and enjoyed by the residents, family, and the wider community.</p> <p>The use of ambassadors to buddy up with residents new to the facility has helped to promote friendships through shared experiences. It has also facilitated feelings of self-worth through supported participation and helped to reduce the risk of social isolation and</p>	<p>The activities programme shows evidence beyond the expected full attainment, enabling residents to integrate, engage with, and make a meaningful contribution to their in-house community. The residents who wish to have an opportunity to contribute in a meaningful way to the wellbeing of the community are supported by the service and provided with opportunity. The activity programme evidenced the actions taken to make the programme meaningful to the residents. Residents interviewed confirmed the positive impact the approach to activities within the facility has had upon them, both in participation and the ability to make a meaningful contribution to the lives of fellow residents.</p>

		culture shock through a change in environment, especially during the Covid lockdown periods. Residents interviewed gave positive feedback regarding the effectiveness of the programme and the benefits they had experienced.	
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End of the report.