# Briargate Healthcare Limited - Briargate Dementia Care Unit

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Briargate Healthcare Limited

**Premises audited:** Briargate Dementia Care Unit

**Services audited:** Dementia care

**Dates of audit:** Start date: 2 August 2021 End date: 3 August 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:** 36

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Briargate Dementia Care Unit provides secure rest home dementia care for up to 40 residents. The service is operated by Briargate Healthcare Limited and is managed by the owner/manager and a clinical manager. Residents and families interviewed spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the Waitemata District Health Board (WDHB). The audit process included review of policies and procedures, review of residents’ and staff records, observations and interviews with residents, family members, staff, contracted health providers and a general practitioner.

The audit has resulted in no areas identified as requiring improvement.

## Consumer rights

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Residents and families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumer Rights’ (the Code) and these are respected. Services provided support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents, and families is promoted and was confirmed to be effective. There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service works with other community health agencies.

The owner/manager and the administrator are responsible for management of complaints. A complaints register is maintained.

## 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. |

The quality and risk management plans include the scope, direction, mission statement and values of the organisation. Monitoring of the services provided and reporting to Briargate Healthcare Limited is regular and effective. The facility is managed by one of the owner/managers and an experienced clinical manager. An administrator is available and supports the management team.

The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends and leads to continuous improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective action plans implemented. Actual and potential risks, including health and safety risks are identified and mitigated. Policies and procedures support service provision and were current and reviewed on a regular basis.

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

Residents’ information is accurately recorded, securely stored and is not accessible to unauthorised people. Archived records can be retrieved as needed. Staff and resident records are maintained using integrated hard copy and electronic records.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |

Briargate’s policies and procedures provide documented guidelines for access to service. Residents are assessed before entry to the service to confirm their level of care. The nursing team is responsible for the assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents’ assessed needs and routines. Interventions are appropriate and evaluated promptly.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activity plans are completed in consultation with family/whānau and residents noting activities of interest. Twenty-four hour activity care plans are in place. In interviews, residents and family/whānau expressed satisfaction with the activities programme in place.

There is a safe medicine management system in place. All medications are reviewed by the general practitioner (GP) every three months. Staff involved in medication administration are assessed as competent to do so.

The food service provides for specific dietary likes and dislikes of the residents. Nutritional requirements are met. Nutritional snacks are available for residents 24 hours a day, seven days a week.

## 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. |

There are processes for managing waste and storage of any chemicals used on site. The building warrant of fitness is current and displayed at reception. Electrical equipment is tested and calibration of all medical equipment occurs as required.

Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Laundry and cleaning are completed on site. Chemicals, soiled linen and equipment are safely managed. Products used are managed for effectiveness. The facility meets the needs of residents and was clean and well maintained. A maintenance person is responsible for the maintenance of the facility.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. A nurse call bell system is in place. Security is maintained.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

There are clear and detailed documented guidelines on the use of restraints and management of challenging behaviours. Due to the nature of this service, there were no residents using restraint or enablers on the days of the audit. Staff interviewed demonstrated a good understanding of restraint use and receive ongoing education in restraint, challenging behaviours, and de-escalation techniques through in-service training.

## Infection prevention and control

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

The infection control management system minimises the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for co-ordinating the education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service and is carried out as specified in the infection control programme.

## 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 93 | 0 | 0 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Briargate Dementia Care Unit (Briargate) has policies and procedures to meet its obligation about the Code of Health and Disability Services Consumers’ Rights (the Code). The Residents’ Code of Rights and responsibilities is discussed with each resident and/or advocate. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training was verified in the training records. The Code is displayed around the facility and provided to residents and family/whānau as part of the admission process. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Residents’ files sampled verified that informed consent had been gained appropriately using the organisation’s standard consent form. These are signed by the enduring power of attorney (EPOA) and the GP makes a clinically based decision on resuscitation authorisation. The CM reported that advance directives were only completed by residents deemed competent, such as those assessed as requiring rest home level of care, and this is discussed during admission process and on an ongoing basis.  Staff was observed to gain consent for day-to-day care, and they reported that they always check first if a consent form is signed before undertaking any of the actions that need consent. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members’ lives. All consent forms are kept in the residents’ files. All residents admitted to the service had activated EPOAs in place. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | As part of the admission process, residents and family/whānau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents were aware of the advocacy service, how to access this, and their right to have support persons. The CM and staff provided examples of the involvement of advocacy services in relation to residents’ care. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. Family/whānau or friends are encouraged to visit or call. Van trips are conducted at least twice a day from Monday to Friday.  The facility has unrestricted visiting hours and encourages visits from residents’ families and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints/compliments policy and associated forms meet the requirements of Right 10 of the Code. The complaints process information is provided to residents/families on admission and there is complaints information available at the reception area in the facility.  The complaints register reviewed showed that nine compliments and five complaints have been received over the last year and that actions were taken through to an agreed resolution. These were documented and completed within the required timeframes specified in the Code. All complaints are effectively closed out and signed off appropriately and dated.  The owner/director and the administrator are responsible for complaints management and follow up. All care staff confirmed a sound understanding of the complaint process and what actions are required. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The clinical manager (CM) reported that information about consumer rights legislation, advocacy services, and the complaints process are provided on admission and displayed at the reception. The Code is available in Māori and English languages. Family members and residents interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process.  The admission pack outlines the services provided. Resident agreements, signed by an enduring power of attorney (EPOA), were sighted in records sampled. Service agreements meet the district health board requirements. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There is a policy and procedure regarding residents’ safety, neglect, and abuse prevention. This includes definitions, signs and symptoms, and reporting requirements. Guidelines on spiritual care to residents were documented. The privacy policy references legislation. There were no documented incidents of abuse or neglect in the records sampled. The general practitioner (GP) reiterated that there was no evidence of any abuse or neglect reported. Family/whānau and residents interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice.  Residents’ privacy and dignity are respected. Staff were observed maintaining privacy. A physiotherapist (PT) visits the facility as required. Residents were able to move freely within the facility. Two residents who were assessed as requiring rest home level of care and had been granted permission to remain at the facility, were free to walk into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident’s individual cultural, religious, and social needs, values, and beliefs had been identified, documented, and incorporated into their care plan. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | Assessments and care plans document any cultural and spiritual needs. Individual needs of residents are assessed on admission as required. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required.  All staff receives cultural awareness training.  Two residents identified as Māori had care provided in line with cultural safety and the Treaty of Waitangi expectations. There were no staff members of Māori descent. Guidelines for the provision of culturally safe services for Māori residents are documented. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner following protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents confirmed they were encouraged to be involved in the development of the long-term care plans. Residents’ personal preferences and special needs were included in the care plans reviewed. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Family members stated that residents were free from any type of discrimination, harassment, or exploitation and felt safe. The two-rest home level of care residents interviewed reported that there were not subjected to or witnessed any form of discrimination, harassment, or exploitation at the service.  The induction process for staff includes education related to professional boundaries, expected behaviours, and the code of conduct. A code of conduct statement is included in the staff employment agreement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.  The clinical manager (CM) stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through the ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed promptness and appropriateness of medical intervention when medical requests are sought.  Staff reported they receive management support for external education and access their professional networks to support contemporary good practice. Some care staff have either level two, three or four New Zealand Qualification Authority (NZQA) qualifications and some had completed online dementia training.  All family members interviewed stated that each resident received good care and support with staff conscious of managing all residents’ identified needs effectively, including challenging behaviours. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Family members stated they were kept well informed about any changes to 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 sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures. Personal, health and medical information is collected to facilitate the effective care of residents. Each resident had a family or next of kin contact log in their files.  There were no residents who required the services of an interpreter; however, staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation has two aged care facilities. Briargate Dementia Care Unit (Briargate) has been in operation since 2000 and is managed by one of two owner/managers. The quality plan was reviewed 4 January 2021. The quality plan supports the strategic, business risk management and emergency plans in place. The strategic and business plan reviewed is dated 2020 to 2022 and this clearly outlines the business and strategic goals. The service philosophy, mission statement and the strategic plan reflect a person/family centred approach to service delivery. This was verified when interviewing family members. Three goals are described in the plan to achieve annually.  The clinical manager reports to the owner/manager monthly and provides adequate information to monitor performance including any emerging risks and issues. Any incidents are notified to the owner/manager.  The clinical manager has only been in this role since 30 November 2020. The administrator has been employed at this facility since November 2011. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements sighted. All in the management team confirmed knowledge of the sector, regulatory and reporting requirements and all have maintained currency through relevant courses and events related to aged care and other topics of interest.  The service holds contracts with the DHB for dementia care service for up to a maximum of 40 beds. On the day of the audit the occupancy was 36 residents. Thirty two dementia care residents, two long term support chronic health care (LTSCHC) under 65 years of age requiring dementia level care.  Two long term care residents are receiving rest home level care. The Waitemata District Health Board (WDHB) are fully informed and supportive documentation is available and meets the requirements and requests made by WDHB. Both residents have signed consent for the continuation of stay and care at Briargate Dementia Care. Full details of their individual backgrounds, current levels of care and rights, and approval information is fully documented in their respective care plans. Six monthly reviews have been completed on the 25 January 2021 and 9 June 2021 for both residents concerned. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | When the owner/manager is absent, the clinical manager is available to carry out all the required duties under delegated authority. The administrator is also available to assist with governance issues that may arise. If the clinical manager is absent, cover is also provided by the clinical manager at the owner’s other site. Senior registered nurses are available to assist the clinical manager on a daily basis. The clinical manager would continue to cover the service after-hours. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a robust business risk management plan that reflects the principles of continuous quality improvement. This includes management of incidents and accidents, complaints, internal audit activities, regular satisfaction surveys, monitoring of outcomes, clinical incidents including infections, restraint minimisation and safe practice. The internal audit system has been developed and implemented for 2021.  Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and risk management monthly meetings. Staff reported their involvement in quality and risk management activities through audit activities and monthly meetings attendance. The clinical manager ensures corrective actions are developed and implemented to address any shortfalls. Quarterly management meetings occur, and minutes are maintained and were reviewed. Goals and objectives are discussed, and progress is noted in achieving the goals set earlier in the year. Multidisciplinary team meetings are held six monthly, to discuss residents, reassessments, referrals to the DHB or any other emerging issues.  Annual staff/resident/family surveys are completed. In February the staff wellness survey was completed. The survey was reviewed with positive feedback provided to the staff. The family satisfaction survey was completed April 2021 and any areas of improvement were acknowledged and included in the quality improvement plan for the service. A new initiative since the previous audit has been put in place with the Briargate Dementia Care seasonal newsletter which has been developed and implemented and all family members receive a copy. Family interviewed enjoyed reading about the activities and events and any updates about the facility and staff. Family also commented about the input they have in to their relative’s care planning and this was appreciated.  Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval by the owner/manager if necessary, distribution and removal of obsolete documents. The system is being managed by the owner/manager and clinical manager with the input of a quality consultant.  The owner/manager (O/M), administrator and the clinical manager are all familiar with the Health and Safety at Work Act (2015) and ensure the implementation requirements are effectively managed. Training is provided to all staff annually on the quality and risk management system requirements. The service has an up-to-date risk register which is kept at reception. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Policies and procedures and a flow chart are accessible to guide staff on all aspects of incident/accident and adverse event reporting. A sample of incident forms reviewed showed these were fully completed. Incidents were investigated, action plans developed and actions followed-up in a timely manner. All incidents are logged into the electronic system and the hard copy log in each resident’s individual record, is maintained and kept up to date. The clinical manager is responsible for maintaining the data base. On a monthly basis the incident/accident data base is printed off the electronic system and the information is placed into the clinical report. This includes data on the number of falls, skin tears, infections, damage to property, equipment faults and medication errors, security and safety. The clinical manager collates the information, analysis and reports the outcomes and any trends identified to the owner/manager. Any trends are fed back to the staff at the staff/quality meetings held monthly.  The clinical manager described essential notification reporting requirements, including for pressure injuries. There has been one Section 31 Notice completed since the previous audit and that was in relation to the new clinical manager position being filled in November 2020. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resource management policies and processes are based on good employment practice and relevant legislation A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are well maintained by the administrator supported by the clinical manager. The recruitment process does include referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required.  Staff records were randomly selected for review and contained all required documents. An employment checklist has been developed and implemented since the previous audit and was observed on the front cover of each staff record reviewed. Interview records, acceptance letters and curriculum vitae (CV), education records and certificates, job descriptions, the individual employment agreement and appraisal records were all sighted.  Staff orientation/induction booklets which include all necessary components relevant to each role were completed by all newly employed staff. Job descriptions were provided to all staff and a copy is signed and retained in each record reviewed. Staff interviewed reported that the orientation process prepared then well for their role. Staff records reviewed, showed documentation of completed performance appraisals after a three month period and then annually. Records reviewed demonstrated all staff had completed the required training and annual appraisals were evident.  Continuing education is planned annually and includes all mandatory training requirements. The training plan for 2021 was sighted. The administrator maintains an electronic spreadsheet of all education completed for each staff member. Health care assistants (HCAs) have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the service provider’s agreement with the DHB. Approximately 17 health care assistants (HCAs) are employed permanently. Several casual HCAs are available for relief shifts when needed. Currently four HCAs have completed NZQA level 2 requirements, nine have completed level 3, four level 4. Eight of the 17 HCAs are progressing to the next level of the Careerforce training this year. All have completed dementia care education as set out in the age related residential care (ARRC) agreement. The CM and RNs have completed comprehensive online dementia training. First aid training is provided in June and December to ensure all staff have completed this training. Management and registered nurses have also completed relevant training through the DHB and by attending aged care conferences as able. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a rationale for staff coverage of all services provided at Briargate Dementia Care to provide safe service delivery 24 hours a day, seven days a week. The clinical manager adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is provided by the clinical manager. The GP is on call 24 hours a day seven days a week and stated at interview that the current system works well. Staff reported that good access to advice is readily available when needed.  Residents and family reported there were adequate staff available to complete the work allocated to them. Family interviews supported this. Observation of a six week roster cycle confirmed adequate staff cover has been provided with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. There is an activities coordinator, and the activities programme is provided five days a week. There is provision for activities to be available 24 hours a day. In addition, staff are employed for the kitchen, laundry and cleaning services. There is a maintenance person who ensures the facility is well maintained. Staff are contracted, such as the hairdresser and podiatrist and a physiotherapist, if and when needed. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Residents’ records are held both electronically and paper-based. Staff have individual passwords to the medication management system and registered nurses (RNs) on the interRAI assessment tool. The visiting GP and allied health providers also document as required in the residents’ records. All hard copies are kept securely in the locked cupboards. Hard copy archived records are stored safely and securely on-site. There is an effective system for retrieving both hard copies and electronically stored residents’ records.  All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The admission policy for the management of inquiries and entry to Briargate is in place. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and communicated to the family/whānau of choice, where appropriate, local communities, and referral agencies. Completed Needs Assessment and Service Coordination (NASC) service authorisation forms for residents assessed as requiring dementia level of care were in place. Emails from the district health board granting permission for the two-rest home level of care residents to stay at the facility were sighted. Residents assessed as requiring dementia level of care were admitted with consent from EPOAs and documents sighted verified that EPOAs consented to referral and specialist services. Evidence of specialist referral to the service was sighted.  Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. The family/whānau interviewed confirmed that they received sufficient information regarding the services provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service.  Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents’ records to confirm this. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation.  Indications for use are noted for pro re nata (PRN) medications, allergies are indicated, and photos were current.  Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from the hospital or any external appointments. The RNs check medicines against the prescription and these were updated on the pharmacy delivery forms.  The GP completes three monthly reviews.  Medication competencies were completed annually for all staff administering medication.  There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. Monitoring of medicine fridge and medication room temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Records were sighted.  The RN was observed administering medications safely and correctly. Medications were stored safely and securely in the trolley and locked treatment room.  There were no residents self-administering medications. Self-administration medication is not encouraged due to the residents’ impaired cognitive state.  The service had no residents prescribed controlled drugs. Outcomes of as required (PRN) medication were consistently documented. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The kitchen service complies with current food safety legislation and guidelines. The food service is managed by two cooks and the other cook has been with the organisation for 12 years. There is an approved food control plan for the service which expires March 2022. Meal services are prepared on-site and served in the respective dining areas. The menu was reviewed by the registered dietitian on 12 April 2021. The kitchen staff have current food handling certificates.  Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. All alternatives are catered for. The residents’ weights are monitored regularly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents throughout the day and night when required.  The kitchen and pantry were observed to be clean, tidy, and stocked. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. Labels and dates were on all containers. Thermometer calibrations were completed every three months. Records of temperature monitoring of food, fridges, and freezers are maintained. Food is transported in a hot cart box to the respective dining areas.  The residents and family/whānau interviewed indicated satisfaction with the food service.  All decanted food had records of use by dates recorded on the containers and no expired items were sighted. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The CM reported that all potential residents who are declined entry are recorded. When entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer/family is referred to the referral agency to ensure the person will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Residents have their level of care identified through the needs assessment carried out by the NASC agency.  Initial assessments were completed within the required time frame on admission, while residents’ care plans and interRAI assessments are completed within three weeks, according to policy. Assessments and care plans are detailed and included input from the family/whanau, residents, and other health team members as appropriate.  Ongoing evaluations ensure that assessments reflected the residents’ current status. Additional assessments were completed according to the need (e.g., 24-hour behavioural management plans, nutrition, continence, and skin and pressure risk assessments). The RNs utilise standardised risk assessment tools on admission.  In interviews conducted, family/whānau and residents expressed satisfaction with the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The assessment findings and input from the resident and/or family/whānau inform the care plan and assists in identifying the required support to meet residents’ goals and desired outcomes. Plans were resident-focused and stated actual or potential problem/deficits, set goals for meeting these, and detailed required interventions. Short-term care plans were used for short-term needs.  The review process determined the effectiveness of the interventions in ensuring the resident is achieving set goals. The plan is amended, as necessary, to ensure the interventions and goals are appropriate, congruent, and achievable.  Residents assessed as requiring dementia level of care had twenty-four-hour behaviour management plans in place. Behaviour management plans were implemented as required.  Family/whānau and residents confirmed they were involved in the care planning process.  Residents’ files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapists, district nurses, dietitians, and GP. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Six residents’ files reviewed evidenced that care plans developed had interventions that were adequate to address the identified needs of residents.  Significant changes were reported in a timely manner and prescribed orders were carried out. The CM reported that the GP’s medical input was sought within an appropriate timeframe, medical orders were followed, and care was person-centred. This was reiterated by the GP in the interview conducted. Care staff confirmed that care was provided as outlined in the care plan.  A range of equipment and resources are available, suited to the level of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Planned activities are appropriate to the residents’ needs and abilities. Activities are conducted by the life enhancement coordinator who has professional qualifications in management, recreation, and sports and is in the process of enrolling for a diversional therapy course. The activities are based on assessment and reflected the residents’ social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents’ birthdays are celebrated. A resident profile is completed for each resident within two weeks of admission in consultation with the family.  The activity programme is formulated by the life enhancement coordinator. The activities are varied and appropriate for people living with dementia and those assessed as requiring rest home level of care. Residents’ activities care plans were evaluated every six months or when there was any significant change. Van trips are conducted twice a day from Monday to Friday.  Twenty-four-hour behaviour management plans reflected residents’ preferred activities of choice and are evaluated every six months or as necessary. Activity progress notes and activity attendance checklists were completed daily. The residents were observed participating in a variety of activities on the audit days. The planner sighted included balloon bounce, pet therapy, story reading, art, social van rides, exercises and news and views. The planned activities and community connections are suitable for the residents.  Family members and residents reported overall satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is documented on each shift by care staff in the progress notes. All noted changes by the health care assistants are reported to the nursing team in a timely manner.  Each resident’s care plan and InterRAI assessment is evaluated, reviewed, and amended either when clinically indicated by a change in the resident’s condition or at least every six months whichever is earlier. The evaluations reflected the achievement of the set goals over the previous six months. The evaluations are carried out by the RNs in conjunction with family, residents, GP, and specialist service providers.  Where progress is different from expected, the service responded by initiating changes to the care plan. Short-term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whānau are included and informed of all changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents and family/whānau are supported to access or seek a referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP and the nursing team refers to specialist service providers and the DHB. Referrals are followed up regularly by the GP and CM. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.  Acute or urgent referrals are attended to, and the resident is transferred to the public hospital in an ambulance if required. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and garden waste, infectious and hazardous substances. Appropriate signage is displayed where necessary.  An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material data sheets were available where chemicals are stored, and staff interviewed knew what to do should there be a chemical spill/event.  The maintenance person was not available to interview at audit.  There is adequate provision and availability of protective clothing and equipment and staff were observed using this during the audit. Supplies are accessible to all staff working in all services. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (BWOF) expiry 23 January 2022 is publicly displayed. All buildings, plant and equipment comply with legislative requirements.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for purpose and are maintained. The maintenance person covers two sites. Preferred contractors are used as needed. Planned maintenance is ongoing at both sites. The testing and tagging of electrical equipment and calibration of biomedical equipment was current as confirmed in the documentation provided and reviewed, interviews with the administrator and observation of the environment. An inventory and site history of all electrical equipment is maintained. Daily maintenance to be completed is signed off and dated when completed. The environment was hazard free, residents were safe and independence is promoted.  External areas are also safely maintained and appropriate to the resident groups and setting. There is a new area outside of the facility being developed into a garden and one large deck in the centre of the home. A variety of seating is available and planters with bright flowers were sighted.  Two lounges are available with one being used for recreational activities. A sunroom near the deck area provides a warm area for the residents to sit during the day and to enjoy the views of the raised gardens. The younger people with a disability (YPD) and the two rest home residents have adequate space to walk around as needed and if any equipment is required this is accessible.  Families and staff interviewed confirmed they knew the processes to follow if any repairs or maintenance were required, that any requests are appropriately actioned and that the environment was suitable. Families interviewed confirmed residents use all areas of the facility available and accessible to them. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are a variety of facilities in this dementia care service. There are three separate large showers. All rooms have a separate toilet. All showers are available in close proximity to the residents’ rooms.  Appropriately secured and approved handrails are provided in the toilet/shower areas and other equipment/accessories are available to promote residents’ independence. There are separate staff and visitor toilets available in the facility. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | Adequate personal space is provided to allow residents and staff to move freely if able around within their bedrooms safely. All bedrooms provide single accommodation. There are no shared rooms. Rooms are personalised with photographs, furnishings, furniture and other personal items being displayed.  There is room available to store mobility aids. Mobility aids are available as needed for individual residents to ensure independence and mobility. Staff, residents and family reported the adequacy of the bedrooms and space provided. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas are available in all service areas for residents to engage in activities. The two large lounges are used for recreational purposes, entertainment and relaxation. The seating provided is comfortable and appropriate for the elderly or disabled. There is a separate family/whanau room/sunroom available for private discussions to occur as needed.  There is one sunroom off the activities lounge seen to be well utilised by residents during the day. There is a large separate dining room with adequate seating arrangements. Tables are set up for two and four table settings at the main mealtimes. Comfortable dining settings with comfortable seating are available.  There is a separate hair salon available which is used regularly on a weekly basis. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There is a functional laundry on site with designated staff. Policies and procedures are available to guide staff. All laundry staff are well trained and the laundry assistant demonstrated a sound knowledge of the laundry processes including dirty/clean flow and handling of any soiled linen. The laundry staff member interviewed works 7am to 3.30pm daily two days a week and another experienced staff member five days a week. The staff member demonstrated a good understanding of the role and responsibilities in the laundry and the principles of infection prevention and control.  On the tour of the downstairs laundry there is one large commercial washing machine and two driers installed which are electronically monitored. Family interviewed reported the laundry is managed well and clothes are returned in a timely manner.  The cleaning and laundry staff have completed relevant training for their respective roles and for handling any chemicals required. The staff interviewed felt well supported in their roles. The chemicals are managed by the contracted service provider who checks the supplies and effectiveness of products used. The temperatures and machinery are also checked on a regular basis.  All sluice rooms, cleaners’ rooms and the laundry are locked (key pad access only) when not in use. The cleaning trollies are stored in the locked room when not in use. Filling stations are wall mounted in both the cleaners’ rooms.  Hand sanitizing zones are set up all around the facility for staff to access. One cleaner is available for the facility daily, seven days a week. Two staff are trained as cleaners and have relevant job descriptions available. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies, procedures and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster, local council and civil defence plans guide and direct the facility in their preparation for emergencies.  The current fire evacuation plan was approved by the New Zealand Fire Service on 27 February 2012. The evacuation plan considers residents with special needs, such as dementia. The home is divided into fire zones. A trial evacuation takes place every six months, the last being on the 8 July 2021, with a copy sent to the New Zealand Fire Service. The orientation programme for all new staff includes fire and security training. Staff confirmed their awareness of the emergency procedures and when interviewed staff understood their responsibilities in the event of any emergency.  Adequate supplies for use in the event of a civil defence emergency or other emergency including food, water, blankets, mobile phones and a gas stove and BBQ were available to meet the requirements for up to 40 residents if the facility was fully occupied. There is no generator onsite. In the event of a power outage over a few days or more, a generator would be hired. Emergency lighting is readily available and is tested regularly. Emergency water supplies are adequate for the number of residents. The water storage recommendations for Auckland City Council are met. A check list of all supplies on hand is available and checks occur as per the internal audit schedule reviewed.  Call bells alert staff to residents/staff requiring assistance. Staff are trained to manage those residents with challenging behaviour.  The training programme includes annual training on security, health and safety and emergency management. Staff check the facility between shifts. External doors are activated with key-pad access only. Cameras for security purposes are installed and related signage is available around the facility. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided in the resident’s rooms with wall mounted electric heaters. Hallways have panel heaters and there is a heat pump installed in both the large dining room and the two lounges. The temperature is maintained at a comfortable temperature throughout the facility. Families and staff confirmed this when interviewed. |
| Standard 3.1: Infection control management  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. | FA | There is a documented infection prevention and control programme. The programme is reviewed annually. The review is completed by the CM who is the infection prevention and control coordinator (ICC). There was a well-defined position description for the ICC.  Exposure to infection is prevented in several ways. The organisation provides relevant training. There were adequate supplies of personal protective equipment (PPE) and hand sanitizers. Hand washing audits were completed. The required policies and procedures are documented. Staff are advised not to attend work if they are unwell. Flu vaccines are offered to all staff and residents.  There was a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 were regularly updated. Visitor screening and residents’ temperature monitoring records depending on alert levels by the MOH were documented. There was an infection outbreak in January 2021 which was managed according to policy. The facility was closed to the public for a week, with GP, family/whanau, residents, and relevant authorities notified promptly. Documented evidence of staff and residents affected was sighted. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The CM is responsible for implementing the infection control programme and indicated there are adequate people, physical, and information resources to implement the programme. Infection control reports are completed monthly, and these are discussed at management and staff meetings. Staff confirmed that infections rates information is shared in a timely manner.  The ICC has access to all relevant residents’ data to undertake surveillance, internal audits, and investigations, respectively.  Specialist support can be accessed through the district health board, the medical laboratory, and the attending GP. |
| Standard 3.3: Policies and procedures  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. | FA | The service has documented policies and procedures in place that reflected current best practices. Policies and procedures are accessible and available for staff in the nurse’s station and these were current.  Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitizers, good hand washing technique, and use of disposable aprons and gloves. Staff demonstrated knowledge of the requirements of standard precautions and were able to locate policies and procedures. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff training on infection prevention and control are routinely provided during orientation and annual in-service education. In-service education is conducted by either the CM or other external consultants.  The infection training includes handwashing procedures, donning and doffing protective equipment, and regular Covid-19 updates. Records of staff education were maintained.  The CM completed an infection prevention and control training online in July 2021. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance programme is defined and appropriate to the size and scope of the service. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Results of the surveillance data are shared with staff during shift handovers, at monthly staff meetings, and management meetings. Evidence of completed infection control audits was sighted.  Staff interviewed confirmed that they are informed of infection rates as they occur. The GP was informed on time when a resident had an infection and appropriate antibiotics were prescribed for all diagnosed infections. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The clinical manager is the restraint coordinator and a job description was noted in the personal records reviewed. Due to the nature of this service being a secure dementia care service no restraints or enablers are in use. Training is provided on de-escalation and challenging behaviour techniques. |

# 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.

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| No data to display |

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

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

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

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

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End of the report.