

# Bryant House Limited - Bryant House

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Bryant House Limited

**Premises audited:** Bryant House

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 16 October 2018      End date: 16 October 2018

**Proposed changes to current services (if any):** Build seven villas starting October/November 2018 and a care facility consisting of 17 dementia beds, 30 dual purpose beds (rest home or hospital level) and 13 apartments - either independent or rest home/hospital level. Estimated start date July 2019.

**Total beds occupied across all premises included in the audit on the first day of the audit: 32**



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

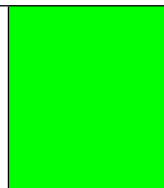
Bryant House provides rest home and rest home dementia level care for up to 33 residents. The facility is operated by Bryant House Limited.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the service's contract with the district health board. The audit process included the review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

Areas requiring improvement from the previous audit relating to planned activities in the dementia unit and an annual review of the infection control programme have been addressed. The finding relating to a designated person who is skilled in providing planned activities for residents in the dementia unit remains open. An area requiring improvement from this audit relates to the time allocated for planned activities for residents in the rest home.

## 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.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreter services from the local district health board (DHB) or Age Concern if required.

The facility administrator is responsible for the management of complaints and a complaints register is maintained. There has been an investigation by the Health and Disability Commissioner since the previous audit.

## 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.

Bryant House Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented. Systems are in place for monitoring the service, including regular meetings of key staff with the owner/general manager.

The facility is managed by the owner/general manager who has a background in management. The general manager is supported by a facility administrator and clinical manager who is a registered nurse. The clinical manager is responsible for oversight of the clinical service in the facility.

There is an internal audit programme. Quality data is being collected, collated and analysed. Graphs of clinical indicators are available for staff to view along with meeting minutes. Corrective action plans are developed, implemented, monitored and signed

off as being completed to address any areas that require improvement. Adverse events are documented on accident/incident forms. Meetings including staff, quality and RN/care giver meetings and are held on a regular basis.

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

There are policies and procedures on human resources management. Human resources processes are followed. An in-service education programme is provided, and staff performance is monitored. Care staff are encouraged to complete the New Zealand Qualifications Authority Unit Standards. There is a documented rationale for determining staffing levels and skill mix. Staffing levels meet contracted requirements.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Shift handovers and communication sheets guide continuity of care.

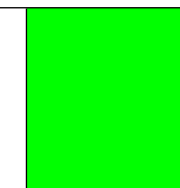
Care plans are individualised, based on a comprehensive and integrated range of clinical information. Health variation care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is overseen by an activities coordinator and provides residents in the rest home with a variety of individual and group activities and maintains their links with the community. Residents in the secure unit have activities provided by the unit's care staff. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by care staff, all of whom have been assessed as competent to do so.

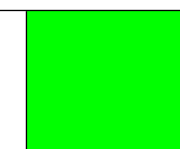
The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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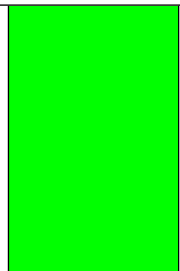
A current building warrant of fitness is displayed. There have been no structural alterations since the previous audit.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The policy and procedure meets the requirements of the restraint minimisation and safe practice standard. There were no residents using restraint or enablers during the audit.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, with data analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.



## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	16	0	0	1	0	0
<b>Criteria</b>	0	39	0	0	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission and there is complaints information and forms available at the main entrance to the facility.</p> <p>The complaints register is up to date and showed four complaints have been received since the previous audit and none for 2018. The facility administrator (FA) is responsible for the management of complaints. Documentation reviewed evidenced Right 10 of the Code was met. Staff interviewed demonstrated a good understanding of the complaints process and what actions are required.</p> <p>The general manager (GM) and the FA reported there has been an investigation by the Health and Disability Commissioner relating to a staff member's behaviour in 2016. A letter from the Health and Disability Commissioner dated April 2018 stated there was no further action required. There have been no other investigations by external agencies since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Residents and families reported they were kept well informed about any changes to their or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>procedures that meet the requirements of the Code of Health and Disability Services Consumers' rights (the Code). Interpreter services can be accessed through the DHB or Age Concern. The facility administrator (FA) reported there are currently no residents who require an interpreter.</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>Bryant House is privately owned and operated. A business plan and a quality and risk management plans were reviewed that include a mission statement, philosophy, vision, objectives and a strengths, weaknesses, opportunities and threats (SWOT) analysis. An organisational flowchart shows the structure and reporting lines within the organisation. The service philosophy is in an understandable form and was available to residents and their family / representative or other services involved in referring clients to the service. Systems are in place which defined the scope, direction and goals of the organisation as well as the monitoring and reporting processes against these systems.</p> <p>The GM works in the business and meets with key staff daily to discuss activities at Bryant House. The GM has owned Bryant House since 2007, is actively involved in the aged care sector and is the chairperson for the Hawke's Bay branch of the aged care association. The GM is supported by an experienced clinical manager (CM)/RN. The CM has been in this role since 2012 and prior to this appointment was a RN working on the floor at Bryant House. The CM is responsible for oversight of clinical care provided to residents. The CM completed a leadership course in 2017 and leads the Careerforce programme. The GM and CM are also supported by the FA, an RN and a quality improvement team consisting of other staff members from within the facility. The clinical service is overseen by an external RN specialist.</p> <p>Bryant House is certified to provide 16 rest home and 17 rest home dementia level beds. On the day of audit all dementia beds were occupied and there were 14 rest home level residents and one hospital level care resident who has been granted dispensation until the 17 December 2018, by HealthCERT. Bryant House has contracts with the DHB for aged related residential care, respite and day care services, long term support-chronic health conditions, mental health in ARRC, and restore ARRC - residential care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>Quality and risk management plans includes goals, six objectives and guides the quality programme. Internal audits have been completed as per the audit programme for 2018. Quality data is being collected, collated and analysed to identify trends. Corrective actions are developed and implemented to improve service delivery following completion of internal audits, surveys, incident/accidents, complaints and any deficits identified at the various meetings. There was good evidence of monitoring to ensure corrective actions have been effective. The CM and FA demonstrated good knowledge relating to quality and risk management.</p> <p>Meeting schedules and minutes evidenced monthly quality and staff meetings are held. Meeting minutes evidenced</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>reporting of clinical indicators including trends and graphs. Minutes of meetings and graphs are available in the staff room for staff to read. The CM also holds weekly meetings with care staff and observation and interviews of staff provided evidence of a comprehensive review of residents and any other matters expressed by staff for discussion. This forum is also used for education with regards to any health event a resident may be experiencing. Resident meetings are held at least two monthly and family meetings six monthly. A two-monthly newsletter is also generated and given to residents and sent out to families which gives useful information about the activities at Bryant House.</p> <p>Policies and procedures are reviewed and were current and fully implemented. They are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. An interRAI policy includes assessment, planning and evaluation. Staff are updated on new/reviewed policies and this was confirmed during interviews of staff. Staff confirmed the policies and procedures provided appropriate guidance for the service delivery.</p> <p>The risk register includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. The hazard register includes actual and potential health and safety hazards and the actions put in place to minimise or eliminate the hazard. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is responsible for hazards and demonstrated good knowledge. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse events on an incident/accident form. An incident/accident register is held on each resident's file. Incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated and analysed by the CM and FA and trends shared with staff through meetings. All incident/accidents are entered into a facility register. Families confirmed they are notified of incidents/accidents in a timely manner.</p> <p>The FA and CM described essential notification reporting requirements, including for pressure injuries and health and safety issues. The FA advised there have been no essential notifications to external agencies since the previous audit.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>orientation, competency assessments, education records, police vetting and interview documents.</p> <p>New staff are required to complete the orientation programme prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.</p> <p>The education programmes for 2017 and 2018 were reviewed. The programme is the responsibility of the CM. Staff attend study days at another local aged care facility and the CM and RN also attend external education, including at the local DHB. Training is also provided at handover and at the weekly caregiver meetings. Individual records of education are maintained as are competency assessments. Staff files evidenced education records and competency assessments including for medication management. The CN and RN are interRAI trained and have current competencies.</p> <p>A New Zealand Qualification Authority education programme is provided for staff and all staff have completed or are currently completing the dementia modules. The CM is the assessor for the service. All staff have completed at least eight hours of inservice education in the past 12 months. Current first aid certificates were sighted in staff files.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. Rosters reviewed showed staffing levels are adjusted to meet the changing needs of residents, resident acuity, occupancy and the environment. Staff are also consulted about any changes in workloads; staff and the FA confirmed this. The CM works Monday to Thursday 7.30am to 3.30pm. The RN works Monday, Tuesday, Thursday and Friday. 8.30am to 4pm. The CM and RN are rostered week about on call after hours. The GM is on call for non-clinical concerns. In the rest home, two caregivers are on the morning shift and three caregivers are on in the dementia unit. The afternoon shift has one caregiver in each area with a third who floats between the two areas. The night shift consists of a caregiver in each area. There is at least one staff member per shift with a current first aid certificate. Care staff are responsible for providing planned activities in the dementia unit and an activities coordinator provides activities in the rest home four days per week and four hours a day. (see criterion 1.3.7.1)</p> <p>Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and families reported there is enough staff on duty to provide them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.</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>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a manual system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the fridges and the storage of medicines were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There were no residents in the rest home or the secure unit who self-administer medications at the time of audit. Appropriate processes were in place to ensure this can be managed in a safe manner if required.</p> <p>Medication errors are reported to the RN and the clinical manager (CM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are used by one GP, and these meet standing order guidelines.</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</p>	<p>FA</p>	<p>The food service is provided on site by a trained chef and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in July-2018. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and registered with the Ministry of Primary Industries (10 August 2018).</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef has completed recent food safety training 18 September 2018.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed.</p>

<p>component of service delivery.</p>		<p>The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</p> <p>Residents in the secure unit, always have access to food, with a small kitchenette and fridge available to them. No evidence of unexplained weight loss was sighted in residents' files reviewed in the secure unit.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Moderate</p>	<p>The activities programme in the rest home is provided by an activity co-ordinator, who although had completed some of the diversional therapy training many years ago, is not qualified. The activities co-ordinator is employed each morning Monday to Thursday. The activities co-ordinator was unavailable for interview on the day of audit. A senior caregiver undertaking the relief role was interviewed.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as residents needs change and as part of the formal six-monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities, outings to local returned serviceman clubs and local social events. Individual, group activities and regular events are offered. The activities programme is discussed at the minuted residents' meetings and resident/family meetings and indicated residents' and family input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered.</p>

		<p>Residents interviewed confirmed they find the programme enjoyable, however there are no activities provided in the afternoons.</p> <p>On admission to the secure unit, the RN undertakes a comprehensive assessment of the resident. A twenty-four-hour management plan is formulated. This includes a social assessment and history to ascertain residents' interests, abilities and social requirements. An activities plan is formulated based on the assessment. There is no designated person skilled in assessment, implementation and evaluation of diversional and motivational activities involved in the activities in the secure unit. Interviews with families verify satisfaction with the activities provided by care staff.</p> <p>Residents on the day of audit were observed to be playing games with care staff and were observed to be settled.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents; care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Except for the respite resident, formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Health variation care plans were sighted for care required when a variance in health status occurs (eg, infections, pain and weight loss). Progress is evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A building warrant of fitness is displayed that expires on the 1 November 2018. There have been no structural alterations since the previous audit.</p> <p>A new complex is to be built in two stages. The first stage is for seven villas to be started end of October/early November 2018. They will be under an occupational rights agreement (ORA). The second stage to start in July 2019 is for a new facility consisting of 17 dementia beds, 30 dual purpose beds, and 13 apartments, either independent or rest home/hospital level. These will also be under ORAs. The GM advised that once the new facility is built, the residents will transfer into the new facility and the current building will be demolished.</p>
<p>Standard 3.1: Infection control management</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level</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>		<p>with input from the CM. The infection control programme is reviewed annually. This addresses a previous corrective action required.</p> <p>The RN with input from the CM is the designated infection control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the CM and tabled at the quality/risk meeting. Infection control statistics are entered in the organisation's electronic database.</p> <p>Signage at the main entrance to the facility requests anyone who is or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control coordinator reviews all reported infections and reports. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p> <p>A 2017 norovirus outbreak is included in surveillance data. Analysis of the outbreak identifies processes in place ensured the outbreak was managed appropriately. The Hawke's Bay DHB were notified and updated in accordance with advice from Public Health.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy has a section on enablers that includes a definition, assessment and evaluation and complies with the requirements of the standard. The restraint coordinator is the CM. The CM reported there are no residents using restraints or enablers and restraint has not been used for years at Bryant House. Staff interviewed demonstrated knowledge of the process should a resident request an enabler and knew the difference between a restraint and an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.</p>

## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>Observation, documentation and interviews evidence a planned activities programme details activities to be carried out in the secure unit. Activities in the secure unit are performed daily by the care staff, based on the care staffs’ day to day assessment of what each resident enjoys doing. Evidence verified activities are guided by information in each resident’s activity plan, based on residents past interests, strengths or skills. There is no designated person skilled in assessment, implementation and evaluation of diversional and motivational activities employed in the secure unit.</p> <p>The activities person in the rest home is employed Monday to Thursday morning. A volunteer offers van outings for residents on Friday morning. Resident interviews express satisfaction with activities in the rest home, however in the afternoons and the weekends they “are left to their own devices”.</p>	<p>Activities provided in the secure unit are not provided by a designated person skilled in providing activities for residents in that area.</p> <p>Residents in the rest home have access to activities Monday to Thursday morning and may require an increase in the amount and availability of</p>	<p>There is a designated person skilled in assessment, implementation and evaluation of diversional and motivational activities employed in the secure unit.</p> <p>A review of the activity hours provided in the rest home are reviewed to ensure residents</p>

			activities provided.	activity needs are met across all days of the week.  90 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.