Heritage Lifecare Limited - Annie Brydon Lifecare

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Annie Brydon Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 October 2017 End date: 10 October 2017

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: 68

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.

General overview of the audit

Annie Brydon Complex (Annie Brydon) provides residential accommodation for up to 71 residents. Currently Annie Brydon provides hospital and rest home care in a mix of rooms and care suites. The care suites are purchased by residents under an Occupational Right Agreement. Annie Brydon is in private ownership.

This provisional audit requested by Heritage Lifecare Limited, was conducted against the Health and Disability Services Standards and the provider's contracts with the Taranaki District Health Board, Hospice Taranaki and the Ministry of Health. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, contracted allied health providers and a general practitioner. Annie Brydon Complex will become Annie Brydon Lifecare on the sale of the facility.

There are no areas requiring improvement relating to this audit.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Resident who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive Māori health plan and related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There is access to formal interpreting services if required.

The service has strong linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

There is current complaint folder and register. There have been no complaints made to the Health and Disability Commissioner since the previous audit or to any other external agency.

Organisational management

Annie Brydon Complex Limited is the governing body and is responsible for the service provided at Annie Brydon. The documented scope, direction, goals, values, and a mission statement were reviewed. There are systems for monitoring the services provided including regular reporting to the governing body.

One of the directors of Annie Brydon is the facility manager. She is supported by a clinical nurse manager who is a registered nurse.

Quality and risk management systems are in place. This includes a programme of internal audits, adverse event reporting, development of corrective action plans, a quality committee, health and safety programme and designated staff member, and regular staff and resident meetings.

There are current hazard and risk registers, both of which are reviewed and updated as required. The facility has a trained health and safety representative who has completed an update on the Health and Safety at Work Act (2015) requirements.

There are policies and procedures on human resources management. Human resources processes are followed. Staff have the required qualifications. In-service education programmes are provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are rostered on duty at all times at Annie Brydon. The clinical nurse manager is on call after hours.

The prospective owner has a detailed transitional plan to manage the process of the potential sale and transfer of ownership. The plan includes identification and management of risks. No changes are planned for the short term.

Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to both facilities is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission and within the required timeframes. Shift handovers guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. 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. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activities programme, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van and a facility car 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 registered nurses and 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 is well organised, clean and met food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

A current building warrant of fitness was on display. All building and plant complies with legislation. There is a maintenance programme. Equipment and electrical checks are included in the maintenance programme.

The most recent audit at Annie Brydon, included changing three of the care suites from single to double accommodation. There is one other double room. These four double rooms are for the use of married couples who wish to use them. All other rooms are single. There is a mix of shared and single full ensuite bathrooms. Adequate numbers of additional bathrooms and toilets are available. There are several lounges, dining areas and alcoves. External areas for sitting and shade are provided.

An appropriate call bell system is available and security and emergency systems are in place.

Staff have access to protective equipment and clothing and this was observed in use. Chemicals, soiled linen and equipment was safely stored. All laundry is washed on the site. Cleaning and laundry systems are audited for effectiveness.

Restraint minimisation and safe practice

Annie Brydon is a restraint free environment. There are a small number of enablers in use, when requested by residents. There are appropriate assessment and monitoring processes.

Infection prevention and control

The infection prevention and control programme, led by an experienced and appropriately trained infection control officer, aims to prevent and manage infections. Specialist infection prevention and control advice is accessed from the district health board and an external advisor. The programme is reviewed annually.

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

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

Summary of attainment

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

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

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Annie Brydon Lifecare (Annie Brydon) have developed policies, procedures and processes to meet their obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed at the facility 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 employed and in ongoing training, as was verified in training records
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 provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including consent for photographs, outings, names on doors and the collection and sharing of health information. Advance care planning, establishing and documenting enduring

		power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur. Staff were observed to gain consent for day to day care on an ongoing basis.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Brochures related to the Advocacy Service were also displayed in the facilities. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed. A resident advocate regularly visits. An interview with the advocate, verified residents were well informed of their rights, the advocacy service, and were aware the advocate will deal with concerns they may have and are not comfortable to deal with. Any concerns residents or family members have are dealt with promptly by the facility manager (FM), however concerns expressed were very few.
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. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. 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 (refer 1.3.7.1). The ability for residents to maintain links with family and community has been enhanced at Annie Brydon. Documentation in 2014 expressed some residents and their family member's desires to go out; however, this was limited by the resident being in a wheelchair. Mobility taxis are not available in Hawera and the Annie Brydon van was cumbersome and often not available due to facility requirements and arranged outings. A special purpose vehicle was purchased, especially designed to allow access to one resident in a wheelchair. It is easily operated.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy and procedure which is consistent with Right 10 of the Code. The policy and complaint forms are available throughout the facility along with information about the Code of Health and Disability Services Consumers' Rights and the Nationwide Advocacy Service (the Code). There have been no complaints since the last onsite audit. The complaints which have been received have been managed within the time frames of the Code. Complainants have been responded to respectfully and complaints have been resolved to the satisfaction of the complainants. Staff members interviewed understood their responsibilities for supporting residents and family members to make complaints and raise concerns. They receive training in the complaints process and the Code at their orientation and the ongoing annual training programme. Regular residents' surveys are sent out through the internal audit process (See standard 1.2.3). The survey includes questions about the resident's knowledge of the Annie Brydon complaints process. Responses indicate that residents have an awareness of the process and are consistently between 90 – 100%. Residents and family members interviewed during the audit were very satisfied with the services received at Annie Brydon.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided, discussion with staff, and by ongoing discussion with the facilities resident advocates. Information on the Code, the advocacy service, how to make a complaint and feedback forms were displayed in the entrance foyer.
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	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit when attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information and enabling residents' privacy for discussions. All residents have a single room, with the exception of one room which is shared with another person with their consent. Residents are encouraged to maintain their independence by involvement in community activities, participation in clubs of their choosing and the provision of opportunities to maximise individuals choice (refer 1.1.12 and 1.3.7.1). Each plan included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed by staff and training.
Standard 1.1.4: Recognition Of Māori Values And Beliefs	FA	Staff support a number of residents who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of

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.		Waitangi are incorporated into day to day practice, as is the importance of whānau to Māori residents. There is a current cultural assessment for all residents who identify as Māori that includes a holistic model within Maoridom (Whare Tapa Wha). Current access to resources includes the contact details of local cultural advisers and the community. Guidance on tikanga best practice is available and is supported by staff who identify as Māori. Interviews with two residents who identify as Māori verified that staff acknowledge and respected each individual's cultural needs.
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	Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. Residents monthly satisfaction questionnaires includes evaluation of how well residents' cultural needs are met and this supported that individual needs are being met.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner (GP) for Annie Brydon expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses (RNs) have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct as part of their employment agreement. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.

Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through access to online training, evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, district nurses, dieticians, services for older people, mental health services for older persons, and education of staff. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own on-line learning with guidance from the clinical nurse manager (CNM) to support contemporary good practice. Other examples of good practice observed during the audit included the processes in place to manage the limitations imposed by the services location.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated 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 evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Interpreter services are accessed via the District Health board (DHB) when required. Staff knew how to do so, although reported this was rarely required due to all present residents being able to speak English, staff able to provide interpretation as and when needed and the use of family members when a resident is unable to speak. Staff were observed communicating effectively with residents and family.

Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Annie Brydon is privately owned by a group of directors, one of whom is the facility manager of the Annie Brydon complex. The facility manager is experienced, having worked in the facility for 20 years and managed the rest home wing prior to becoming the facility manager two years ago. The management of clinical services is the responsibility of the clinical nurse manager (CNM) who has been in their role for two years. Prior to this appointment, the CNM was employed as a team leader/RN at Annie Brydon. The annual practising certificate for the clinical nurse manager was current. Both the facility manager and clinical nurse manager have current education. There are business plans, which are reviewed annually and outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. The service holds contracts with and Taranaki District Health Board (DHB) for age related residential care, age related hospital care, long term chronic health conditions and respite care, with the Taranaki Hospice for palliative care and the Ministry of Health for residential services for people under the age of 65. On the first day of the audit 68 residents were receiving services, eight hospital level residents, 58 rest home level (29 private and 29 subsidised), one resident is under 65 and one resident was receiving respite care. Except for the resident who is under 65, all other residents were receiving services under the provider's contract with the Taranaki District Health Board. The prospective owners, Heritage Lifecare Limited (HLL), provide aged related services and management services in other locations and understand the contracts the present owner has with the Taranaki DHB, the Ministry of Health and Taranaki Hospice. Heritage Lifecare's senior quality and compliance manager was interviewed and provided evidence of HLL's transition plan. Regular transition meetings are held to monitor progress and responsibilities to be completed within set timeframes. No changes are planned to change the registered nurse full time equivalents or structure of the organisation, apart from the facility manager who is one of the directors, who is selling. Should the sale go through, they will consider increasing the number of dual use beds at the next onsite

		audit.
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	In the absence of the facility manager, the clinical nurse manager deputises. When the clinical nurse manager is absent, a team leader/RN takes responsibility for management of the facility with support from the organisation's quality manager. The facility manager is one of the current owners and directors and, should the sale go through, is not intending to remain at the facility. The senior quality and compliance manager report that HLL will replace the facility manager with an appropriately skilled and experienced person. If needed an interim person will be appointed to work with the clinical nurse manager to manage the facility until a new facility manager can be appointed.
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 planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and accidents, complaints and concerns, pressure injuries, internal audits and corrective actions, a monthly resident satisfaction survey, and monitoring of all quality improvement data at monthly quality meetings. Meeting minutes reviewed confirmed there is regular review and analysis of quality indicators, summarised adverse event data, results of internal event data and corrective action plans and their implementation. Staff members receive information through graphed data and a summary of information provided at staff meetings and ward meetings and a newsletter. There is a calendar of internal audits which are conducted by the clinical nurse manager. Corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed monthly, with a small number of residents (six) sampled at a time. Surveys demonstrated a consistently high level of satisfaction in the 90-100% across the range of indicators.

		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 and prevention and management of pressure injuries. 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, distribution and removal of obsolete documents. The quality manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. There are appropriate policies and procedures to meet the requirements of the Health and Safety at Work Act (2015). HLL has their own quality and risk management plan and system. Their acquisition process includes a gradual process of replacing the new facility's systems and procedures with HLL's. Management and clinical indicator reports will be implemented first. Other policies, procedures and forms will be implemented gradually over time to ensure this is effective and meets the needs of staff members.
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	Staff document adverse events on an accident/incident form. A sample of incidents/accident 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, analysed and reported to the quality committee, and summarised data provided to staff (as noted in Standard 1.2.3). Members of the management team described essential notification reporting requirements, including for pressure injuries. They advised there have been and no notifications of significant events made to the Ministry of Health, or other external agency, since the previous audit, and in the last 12 months. There are no legislative or compliance issues which HLL would need to manage if the sale is successful.

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 resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Practising certificates and professional registrations for contracted health and allied health professionals are monitored by the clinical nurse manager, as well those of the nursing staff. All are current. Staff orientation includes the necessary components relevant to the role. Staff reported that their orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and annually thereafter. Continuing education is planned on an annual basis, and includes mandatory training requirements. Some care staff have completed a New Zealand Qualification Authority certificate relevant to the sector while others have relevant training provided at Annie Brydon. All attend the ongoing training programme run at the facility, with associated knowledge and competency assessments. There are currently three trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Another registered nurse is scheduled to attend interRAI training before the end of this year. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. During interviews staff members reported that they have access to sufficient training to perform their roles competently and provide safe care. The resident satisfaction survey results confirm that residents are satisfied with the ability of staff and the services they receive.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from	FA	Annie Brydon has a documented and implemented process for determining staffing levels and skill mixes to provide safe service

suitably qualified/skilled and/or experienced service providers.		delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. The clinical nurse manager is on call, with staff reporting that good access to advice is available when needed. Staff members interviewed reported there were adequate numbers of staff available to provide safe services. Residents and family interviewed supported this. Observations and review of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. All nursing staff, and the activities coordinators, have first aid certificates. There is 24//7 registered nursing coverage in the hospital. Heritage Lifecare has their own policy for the provision of safe staffing in its facilities. This is based on the Indicators for Safe Aged Care and Dementia Care for Consumers handbook. These Indicators and HLL's policy provide for staff having first aid certificates, appropriate ongoing training and 24/7 registered nursing staff for residents receiving hospital level care.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable. Archived records are held securely at each site and are readily retrievable using a cataloguing system.
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	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission

services has been identified.		and meet with the CNM. They are also provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care. Family members and residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses a transfer form to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, care plan and recent progress notes is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed a planned, co-ordinated transition.
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 is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management 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. Medications are supplied to the facilities in a pre-packaged format from a contracted pharmacy. These medications are checked against the prescription by a RN. All medications sighted were within current use by dates. Clinical pharmacist input is provided at both facilities

		on request. 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. The records of temperatures for the medicine fridge were within the recommended range. 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 reviews were consistently recorded on the medicine chart, and included a review of the use of standing orders medication. There were four residents who self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner. Medication errors are reported to the CNM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive organisational analysis of any medication errors, and compliance with this process was verified. Standing orders are used, were current and comply with guidelines.
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 food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in October 2016. Recommendations made at that time have been implemented. 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 cooks have undertaken a safe food handling qualification, with kitchen

		assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There was sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.
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	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the CNM. There is a clause in the access agreement related to when a resident's placement can be terminated.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools, such as pain scale, falls risk, skin integrity and nutritional screening as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed, by one of three trained interRAI assessors, with an additional RN about to commence the training.

Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by interRAI assessments are reflected in the care plans reviewed. Care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	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 service has a commitment to 'zero tolerance of pressure injuries', and evidence verifies success in treating and preventing PIs. All PIs in the facility at the time of audit are been acquired elsewhere, however there is a commitment to resolve these using best practice guidelines, promptly. Residents identified as a falls risk, have documentation identifying strategies to manage the risk, as do residents with episodes of challenging behaviour. The GP and CNM interviewed, verified that medical input is sought in a timely manner and that medical orders are followed. 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.
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,	FA	The activities programme at Annie Brydon is provided by two activities officers. A social assessment and history is undertaken on admission to

and the setting of the service.		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. 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. Individual, group activities and regular events are offered. Examples include lunch outings at a local club, attendance at the community group meetings and attendance at the local monthly dances. An initiative has been implemented by the activities officers to involve the women's club, local kindergarten and the school in activities at Annie Brydon. Evidence verifies improved satisfaction and participation in the programme since the implementation of this initiative. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Residents' meetings are bimonthly and run by the activities officers. Interviews, meeting minutes and satisfaction surveys verified resident and family satisfaction with the programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans were consistently reviewed and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans, were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any

		resulting changes.
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 are supported to access or seek referral to other health and/or disability service providers. Although the service has a main medical provider, residents may choose to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP, RN or CNM sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.
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 infectious and hazardous substances. Appropriate signage is displayed in the sluice and laundry rooms and in other locations 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 safety data sheets were available where chemicals are stored. Staff were familiar with the management of chemicals they use and accessing advice and support if needed. There is provision and availability of protective clothing and equipment and staff were observed using this.
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 (expiry date 15 October 2017) was publicly displayed. The environment has been purpose built and is well maintained. Efforts are made to ensure the environment is hazard free, that residents are safe and independence is promoted. There are hand rails throughout the facility in the wide corridors. Floor coverings are

		carpet and linoleum (in bathroom and dining areas). Residents were observed moving around the facility independently, using mobility equipment and with assistance when needed. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. External areas are safely maintained and are appropriate to the resident groups and setting. HLL are not intending to make structural changes to the facility. However, they are considering an increase in the bed types at the next onsite audit as noted in standard 1.2.1.
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 is a mix of rooms with ensuite bathrooms, some of which are shared. Remaining rooms have access to an adequate number of shared bathrooms and toilets. There are appropriate handrails in the bathrooms and shower chairs and equipment to provide a safe environment for residents when bathing. Resident satisfaction survey results indicate that residents are satisfied with the environment. Results are consistently in the early 90% points.
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	There is a mix of room sizes at Annie Brydon. They include 24 care suites which residents purchase an Occupational Right Agreement (ORA) to occupy and receive (currently) rest home level care. Three of these care suites have been approved for occupation by couples. All ORA care suites are the same size, have a bedroom, bathroom and living room, with a small kitchenette. The other 44 rooms vary in size. Of these, one large room has previously been approved for double occupation by a couple. All rooms provide adequate personal space to allow residents and staff to move around within their bedrooms safely. Rooms are personalised with furnishings, photos and other personal items displayed. There is room to store mobility aids, wheel chairs

		and mobility scooters. Residents, families and staff reported the adequacy of bedrooms.
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	At Annie Brydon, numerous areas are provided for residents to use for activities, dining, relaxing and privacy. There are two very large and one small lounge areas in the facility. There are two dining rooms, both of which provide generous space for residents to move freely, with their mobility equipment. These areas were observed being used by residents during the audit. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents, families and staff confirmed and observation evidenced these areas are easily accessed.
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	Laundry is undertaken on site in a dedicated laundry. Care staff in the rest home and a dedicated laundry staff member in the hospital wing demonstrated a sound knowledge of the laundry processes, dirty to clean flow and handling of soiled linen. The resident satisfaction survey results confirmed that the laundry is managed well and their clothes are returned in a timely manner. There is appropriate training for staff members, as confirmed in interview of cleaning staff and review of training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Cleaning and laundry processes are monitored through staff members monitoring their own work and the internal audit programme.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are policies and procedures which guide the facility in emergency planning, preparation and response. Appropriate notices are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their planning for civil defence

		emergencies and include fire and other emergencies. The current fire evacuation plan was approved by the New Zealand Fire Service on 17 July 2013 (when structural changes were made to the facility). A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 28 June 2017. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, and a gas BBQ's were sighted and meet the requirements for the number of residents in the facility. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. The call system can be audited through the electronic monitoring system. The clinical nurse manager and facility manager discussed how they are able to check on response times if concerns are raised. During the audit it was noted that staff members responded to call bells promptly. Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night.
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. There is gas central heating which is ducted through the ceiling. Rooms have natural light, opening external windows and appropriate curtains or blinds. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of	FA	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 to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.		Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the infection control officer (ICO) and IPC nurse at the DHB. The IPC programme and manual are reviewed annually. The CNM is the designated ICO, whose role and responsibilities are defined in a job description, and extends to cover both facilities. Infection control matters, including surveillance results, are reported monthly to the facility managers, quality manager and general manager and tabled at the quality meeting. This committee includes the general manager/facility manager, ICO, the health and safety officer, and representatives from food services and household management 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.
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 ICO has appropriate skills, knowledge and qualifications for the role, and has been in this role for 21 months. She has undertaken training in infection prevention and control and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control team at the DHB are available. The nurse has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The ICO confirmed the availability of resources to support the programme and any outbreak of an infection.
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	FA	The IPC policies reflect the requirements of the IPC standard and current accepted good practice. Policies were last reviewed in 2016 and included appropriate referencing. Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-

are practical, safe, and appropriate/suitable for the type of service provided.		sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of IPC policies and practices.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Priorities for staff education are outlined in the IPC annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses and the ICO. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance was maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education had been provided in response. An example of this occurred when there was an increase in respiratory infections. Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.
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	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 and management is documented in the residents' clinical records and on an infection reporting form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The ICO reviews all reported infections. Monthly surveillance data is collated, recorded in the resident management system and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via team meetings, quality meetings, staff meetings, staff newsletters and at resident handovers as confirmed

		in meeting minutes sighted and interviews with staff. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality, staff, team and management meetings.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures have definitions of restraints and enablers. The restraint approval group forms part of the quality meetings. Restraint is also an agenda item at the staff meetings. Meeting minutes confirmed this. The clinical nurse manager is the restraint coordinator. Annie Brydon has made a decision to become restraint free and uses alternatives to restraints to ensure residents are safe while remaining as independent as possible. Enablers are used when these are requested by a resident. There are appropriate systems around these to assess need, gain consent and monitor the safety of the resident when the enabler is in use. On the day of audit, two residents were using enablers, and these were used voluntarily at their request. Both residents' files were reviewed and had an assessment which included their consent, a three-monthly review, and the numbers and use of enablers is reported at the monthly quality committee. Staff demonstrated good knowledge about restraints and enablers. HLL have appropriate policies and procedures to guide the use of restraints and enablers. Policies focus on the minimisation of restraint use and provide processes for the assessment, implementation and monitoring of enablers when these are requested by residents. Both enablers and restraints are reported through the clinical indicator reporting by each facility in the HLL group.

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.

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.

No data to display

End of the report.