

Presbyterian Support Central - Brightwater Centre

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 Health and Disability Auditing New Zealand 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:	Presbyterian Support Central
Premises audited:	Brightwater Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 December 2014 End date: 10 December 2014
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:	49

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Brightwater is part of the Presbyterian Support Central organisation (PSC). The facility provides rest home, hospital and dementia level care for up to 63 residents. There were 30 hospital and 19 residents requiring dementia level care on the day of audit. The six rest home beds are currently closed for renovations. The organisation has committed resources and has available a quality coordinator and management is supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director. A comprehensive orientation and in-service training programme is in place that provides staff with appropriate knowledge and skills to deliver care and support.

The service has addressed one of the two previous shortfalls around an aspect of medication documentation. Further improvements are required around aspects of care planning.

This audit identified improvements required around aspects of the quality and risk programme, aspects of human resources, aspects of medication and aspects of activity care plans.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has an open disclosure policy stating residents and/or their representatives have a right to full and frank information and open disclosure from service providers. There is a complaints policy and an incident/accident reporting policy. Family members are informed in a timely manner when their family members health status changes. The complaints process and forms for completion are available in the reception area. Brochures are also freely available for the Health and Disability and advocacy service with contact details provided. Information on how to make a complaint and the complaints process are included in the admission booklet and displayed throughout the facility.

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.		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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Brightwater is part of the Presbyterian Support Central organisation. The service has a new manager who has been employed since August 2014. The manager has a background in occupational therapy and management experience. The manager is supported by a clinical nurse manager with a background in aged care. Presbyterian Support Services Central has an overall

quality monitoring programme (QMP) that is part of the quality programme and external benchmarking programme. Improvements are required around the quality programme.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support and residents, family and staff state that there is sufficient staff on duty at all times. Improvements are required around aspects of human resources.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff. This covers relevant aspects of care and support.

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 low risk.
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Registered nurses are responsible for each stage of service provision. Service delivery plans demonstrate service integration. Care plans are reviewed three monthly. There remains an improvement required around care planning documentation to reflect resident support needs. Resident files include notes by the GP and allied health professionals. There is a diversional therapist responsible for planning and implementing activities and identifying different needs that are appropriate to their age culture and differing health status. An improvement is required around the completion and review of activity plans.

There is a medication management system in place. Previous shortfalls around controlled drugs and documentation have been addressed. There is an improvement required around the standing orders.

The company dietitian reviews the menu. Residents likes/dislikes and dietary preferences are known and alternative foods offered. There are nutritious snacks available in the dementia care facility 24 hrs. Residents are complimentary about the food services.

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.

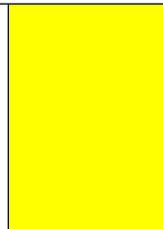


Standards applicable to this service fully attained.

The building has a current warrant of fitness that expires 7 April 2015. There is an improvement required around carpet cleaning (# link 1.2.3.8).

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.



Some standards applicable to this service partially attained and of low risk.

The organisational policies relating to restraint minimisation and safe practice require review to ensure that they align with current standards. The service has 10 enablers in use. Four hospital residents with restraints were classified as enablers. Staff receive training in relation to restraint minimisation. The service maintains a restraint/enabler register in each level of service. Improvements are required around the review of the restraint policy, documentation of associated risks of restraint and monitoring.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control nurse at PSC Brightwater completes a monthly infection summary which is discussed at clinical and management meetings. Infection control education is provided and records maintained. All infections are recorded on the surveillance monitoring summary including an outbreak in 2014.

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	11	0	5	1	0	0
Criteria	0	34	0	5	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a clearly documented process for making complaints and this is communicated to residents/family/whānau. There is a copy of the process documented on the notice-board in the service and a complaints box.</p> <p>Documentation including follow up letters and resolution demonstrates that complaints are overall well managed. Discussion with five hospital residents and one relative (dementia) confirmed they were provided with information on complaints and complaints forms and one family member described having a concern addressed immediately. Complaint forms were visible for residents/relatives in various places around the facility.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry.</p> <p>There is a complaints folder and register that includes complaints verbal and written and includes sign-off. All complaints are included on the complaints register with evidence of follow up and resolution. Seven written complaints for 2014 were reviewed. All complaints were well documented including investigation, follow up, feedback (verbal, letter) and resolution. The service is currently working through a process of a complaint from the Health and Disability Commissioner 2 April 2014.</p>

		<p>E4.1biii. There is written information on the service - philosophy and practice for Dementia care - particular to the dementia unit included in the information pack including (but not limited to): a) the need for a safe environment for self and others; b) how behaviours different from other residents are managed and c) specifically designed and flexible programmes, with emphasis on:</p> <ol style="list-style-type: none"> 1. Minimising restraint. 2. Behaviour management. 3. Complaint policy.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Discussions with five hospital residents and one family member from the dementia unit all stated they were welcomed on entry and were given time and explanation about services, procedures etc. Resident meetings are scheduled to occur six monthly (# link 1.2.3.6) and the manager and has an open-door policy. A review of incident forms from November 2014 identified that relatives are informed in all cases where appropriate.</p> <p>D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.</p> <p>D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b: One relative (dementia) stated that they are always informed when their family members health status changes.</p> <p>Residents and a relative interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry.</p> <p>D11.3: The information pack is available in large print and advised that this can be read to residents.</p> <p>The service has policies and procedures available for access to interpreter services and residents (and their family/whānau) are provided with this information in resident information packs.</p> <p>The residents and relatives survey conducted in 2013 evidenced overall satisfaction and identified key areas for improvement (# link 1.2.3.6). The service is currently</p>

		collating the survey response for 2014.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Brightwater is part of the Presbyterian Support Central organisation. The facility provides rest home, hospital and dementia level care for up to 63 residents. There were 30 of 33 hospital residents and 19 of 24 dementia level care beds were occupied at the time of audit. There were no rest home beds occupied due to the rest home beds having renovations completed. The organisation has committed resources and has available a quality coordinator and management are supported by a regional manager, a quality team leader, a clinical and professional educator and a clinical director.</p> <p>PSC Brightwater has a documented mission statement, vision, values, corporate commitment and older person's services goals.</p> <p>There is a local risk management plan for 2014.</p> <p>There is an Enliven PSC Brightwater business plan that provides a mission, vision and values and goals.</p> <p>The service has reviewed the management and clinical structure at the service over the past few months. A new manager, clinical nurse manager and clinical coordinators have been employed to support and implement the new structure.</p> <p>The manager has been employed since August 2014 and is a qualified occupational therapist with managerial experience. The manager was absent on the day of the audit due to orientation at PSC central office. The regional manager, who supports the new manager, was present on the day of the audit. PSC provides manager orientation training and support at least every two months across the organisation. Enliven also provides a two day education seminar annually for all managers to ensure that all managers receive at least eight hours annual professional development activities related to overseeing clinical care. The clinical manager has been in the position since July 2014 and has completed orientation and attended compulsory education provided by PSC for all clinical managers.</p> <p>E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimises risks associated with their confused states.</p> <p>ARC D17.4b (hospital) The manager has attended at least eight hours of professional development activities related to managing a hospital since employment.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>The service has a current business and a quality and risk management plan for 2014. Presbyterian Support Services Central has an overall quality monitoring programme (QMP) that is part of the quality programme and an external benchmarking programme that requires improvement at PSC Brightwater. The service reviewed the responsibility of the quality programme at the beginning of the year and due to shortfalls with the implementation of the programme the service has recently reviewed the programme responsibility again. The Quality Co-ordinator has been appointed to the role of Clinical Co-ordinator. The service has identified quality compliance issues and has initiated a quality systems process project 2014/2015 (November 2014). The manager is currently reporting to the regional manager two weekly when the regional manager visits to support the new manager in his role. The manager is responsible for PSC Brightwater only and manager provides a balanced scorecard report to central office.</p> <p>PSC Brightwater has a senior management team (combined quality team) that includes key staff from all areas of the service and a clinical team. The senior management team meeting includes areas for health and safety, infection control, clinical, recreation, education, restraint and projects update. The senior team meet monthly however minutes for August 2014 only were available and sighted. Staff interviewed reported that they were unaware of some of the quality systems but were able to discuss the Eden philosophy / approach.</p> <p>There is an annual staff training programme that is implemented and based around policies and procedures, records of staff attendance, content and evaluations is evidenced. All clinical records not in current use are archived. There is an internal audit schedule, meetings calendar and education plan for 2014. On review of the internal audits it is noted that not all audits have been conducted as per the planner. The range of meetings include: staff, senior management team, clinical, residents, health and safety, registered nurses and Eden Associates. On review of the meetings minutes for 2014 it is noted that not all meetings have been conducted as per the planner.</p> <p>D5.4: The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001 (# link 2.1.1.4). There is a policy review date schedule, and terms of reference for the policy review group. New/updated policies/procedures were historically included in the "What's New"</p>
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	<p>manual for staff however this was unable to be located and reported by staff that it has not been updated during 2014.</p> <p>There is an organisation policy review group that has terms of reference and follows a monthly policy review schedule. The quality monitoring programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The internal audit schedule has been combined to include QMP and external benchmarking monitoring. The audit schedule reviewed has identified that not all audits have been completed as per the schedule. Not all audits have a corrective action plan following results under 85% as per the policy of the service. There is no evidence that staff are advised of audit results and any corrective actions required.</p> <p>The service completes quarterly reports of the IC programme and the H&S programme to PSC Quality Coordinator.</p> <p>The service has a health and safety management system and this includes the identification of a health and safety officer. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Monthly accident/incident/near miss reports are completed by the health and safety officer for each site that breaks down the data collected across the facility and staff incidents and accidents. These are also compared with the last month. There is no evidence that monthly reports are reported to staff at the staff meetings or available for staff to read. Reports including the external benchmarking indicator results that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents. There is an online database for recording accidents and incidents with medication errors reported separately.</p> <p>Incidents and accidents are also reported to PSC clinical director monthly.</p> <p>The service has linked the complaints process with its quality management system. This occurs through the external benchmarking programme and the identification of complaints against a benchmark of the service peers. Monthly manager reports include compliments and complaints.</p> <p>There is an infection control (IC) register in which all infections are documented monthly. A monthly IC report is completed and provided to the quality (meeting report for August only was sighted). The service utilises the external benchmarking programme which analyses service data on a quarterly basis. Infections are also being documented on the electronic database.</p>
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		<p>External benchmarking data analysis is comprehensive and is graphed quarterly. A quarterly benchmarking report from the data is prepared (last report was for the first quarter ending September 2014 sighted). Internal infection control audits are planned and undertaken during the year. The PSC restraint approval group meets six monthly and includes a comprehensive review.</p> <p>Restraint internal audits are completed six monthly. Results are sent to PSC approval group for analysis. The restraint coordinator completes a monthly report which advised this is tabled at the quality committee.</p> <p>A resident/relative survey was conducted September 2013 via the external benchmarking programme with overall satisfaction reported. Key areas for improvement were identified however there is no evidence that a corrective action was implemented or results reported back to residents/relatives. The survey for September 2014 is currently being analysed.</p> <p>A hazard register is established that includes a hazard register for all areas of the facilities. There is also an implemented hazard monitoring form that is implemented for environmental inspections.</p> <p>D19.3 There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management</p> <p>D19.2g Falls prevention strategies such as low, low beds, sensor mats, environmental hazards mobility and transferring assessment, foot wear review and falls risk assessments.</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>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services.</p> <p>D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Incident forms for November 2014 were reviewed. All show the form has been fully completed and reviewed by a registered nurse. All have ongoing review and where appropriate actions to prevent recurrence completed by the clinical coordinators or clinical nurse manager</p> <p>Quality meeting minutes include a comprehensive analysis of incident and accident data and analysis (# link 1.2.3.6). A monthly incident accident report is completed</p>

		<p>which includes an analysis of data collected.</p> <p>D19.3c Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>The service had a noro virus outbreak in March 2014 and public health and the district health board were notified of the outbreak the same day.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity.</p> <p>A copy of practising certificates including RNs, pharmacists, the dietitian, the physiotherapist, occupational therapist and GPs are kept.</p> <p>There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Six staff files were reviewed. Each folder had a file checklist and documentation arranged under personal information, correspondence, agreement, education and appraisals. Two staff files reviewed did not evidence up to date annual performance appraisals and one staff file did not evidence a signed job description.</p> <p>A comprehensive orientation programme is in place that provides new staff with relevant information for safe work practice. This was described by staff and records are kept. A buddy system supports new staff.</p> <p>There are two comprehensive orientation books that include checklists for completion in files reviewed. There is an implemented specific RN orientation book.</p> <p>E4.5d the orientation programme is relevant to the dementia unit and includes a session how to implement activities and therapies.</p> <p>There is a staff training policy and a staff performance monitoring policy. Discussion with the registered nurses and health care assistants confirm that the service provides in-service training and education that covers relevant aspects of care and support and meets requirements. The education programme includes compulsory training days for health care assistants and registered nurses which are run each month. The programme alternates each year. Competencies are identified and completed. Registered nurses attended PSC core professional days and core clinical days annually.</p> <p>Health care assistants are encouraged and supported to undertake external education. Careerforce training is supported. The organisations policy is that after three months of employment all health care assistants must be enrolled in</p>

		<p>Careerforce.</p> <p>D17.8 Eight hours of staff development or in-service education has been provided annually. The organisation has a training framework for registered staff and another for health care assistants/health care assistants. PSC Brightwater has provided health care assistant and RN/EN compulsory training according to the framework.</p> <p>E4.5f Four of nine health care assistants working in the dementia unit have completed dementia specific modules through career force. Four are currently completing the dementia specific modules however three health care assistants have not completed the modules within the required time frame. There is no evidence of one other health care assistant having completed the dementia specific modules. Monthly reporting of training completed and percentages of staff attending is reported to the regional manager and clinical director monthly.</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>	FA	<p>Staff requirements are determined using an organisation service level/skill mix process and documented. Staffing levels are benchmarked against other PSC facilities. Staff levels/skill mix are meeting contract and industry norm requirements.</p> <p>New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. Advised that the roster is able to be changed in response to resident acuity. The external benchmarking quarterly report states that staff hours remain consistently above the mean.</p> <p>There is one clinical nurse manager and two clinical coordinators (one for the hospital and one for the dementia unit).</p> <p>There is an on call roster and the clinical nurse manager and facility manager always available on call.</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>	PA Low	<p>Medication management procedures are in place to guide safe medication practice. PSC Brightwater has appropriate safe medication storage facilities, to ensure that medications will be appropriately stored and safely managed. Medications are checked and signed on arrival by a registered nurse and any pharmacy errors fed back to the supplying pharmacy. RNs and senior HCAs have all completed the reviewed medication self-learning package within the last year. Medication competencies include controlled drugs, insulin and syringe driver (RN only). The hospital unit has palliative care stock and antibiotics available for GP prescribing. Controlled drugs are stored securely only in the hospital unit. Weekly controlled drug</p>

		<p>checks are maintained and the pharmacy conducts six monthly audits.</p> <p>The two medication fridges (hospital and dementia unit) are monitored weekly (temperature recordings were sighted). Medications are kept in locked trolleys. All contents are within the expiry date and eye drops are dated on opening. There were no residents self-medicating. Oxygen and suction was available and weekly checks were sighted.</p> <p>Ten medication files were reviewed (six hospital and four dementia unit). Medication charts have a photo identification of the resident and allergies or nil known allergies are documented. Medication charts are handwritten by the GP/N.P, are legible and meet legislative requirements. All medication charts reviewed identified that the GP or nurse practitioner had seen the resident and reviewed the medication chart at least three monthly. Signing sheets for as required medications include the date and time of administration. This is an improvement since the previous audit. Controlled drugs are given at the prescribed time. This is an improvement since the previous audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food services policies and procedures manual is in place. The head cook is supported by a cook and kitchen hand on mornings and an afternoon kitchen hand daily. All cooks attend a two day peer support and education annually a head office. A monthly teleconference is held. There is a five weekly summer and winter menu that is reviewed by the company dietitian. Recipes are available on the intranet. All residents have a dietary requirements/food and fluid chart completed on admission. The head cook maintains a folder of resident's likes/dislikes and alternative choices are offered. The cook is informed of dietary changes such as high calorie/high protein diets for weight loss. Dietary needs are met including normal, soft, pureed and finger foods. Specialised plates, cups and cutlery are available to promote resident independence at meal times. Residents interviewed commented positively about the meals provided. Residents have the opportunity to provide feedback and suggestions on food services at the resident meeting. The kitchen is well equipped with a good work flow. Fridge and freezer temperatures are recorded daily. Hot food temperatures and serving temperatures are monitored. All facility fridges are monitored. All foods are date labelled. The dry goods are sealed, labelled and off the floor. Goods are rotated with the delivery of food orders. Chemicals are stored safely. Staff were observed to be wearing personal protective clothing on the day of audit. Cleaning schedules (sighted) are in place and maintained.</p> <p>E3.3f. There are nutritious snacks available 24 hours in the dementia care unit.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>All five care plans reviewed were individualised and consumer focused. The three aspects of the Eden approach are documented for each resident and includes interventions to relieve helplessness, loneliness and boredom. Six health care assistants interviewed state they use the care plan to ensure continuity of care delivery is maintained.</p> <p>D16.3f; Five residents interviewed (five hospital) and one dementia care relative stated they were involved in the care plan assessment, planning and review process.</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>The care being provided for hospital and dementia care was consistent with the needs of the resident as evidenced through interview with residents and family. Relatives are notified of changes in a resident's condition. Staff document any changes in care/condition of residents in progress notes.</p> <p>The care staff interviewed stated that they have all the equipment referred to in care plans including a hoist, wheelchairs, hospital lounge chairs, electric beds, continence supplies, dressing supplies and clinical equipment.</p> <p>Wound care plans were completed. A support plan records evaluations and dressing products. Evaluations of wounds and pressure areas (six sacral) were inconsistent. Issues around wound care documentation were identified at the October 2014 clinical meeting and a corrective action plan implemented. There have been ongoing internal audits. Wound care, pressure area management and continence management education has been completed.</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 Low</p>	<p>The service employs a diversional therapist (DT) who has been at Brightwater for one year and has been with PSC for 13 years. The DT attends peer support training annually. Regional meetings for DTs are held three monthly. The DT has a current first aid certificate. The DT is full-time and has a recreational officer two days a week. There are a number of volunteers who assist with activities, outings and men's shed. There are separate recreational programmes for the rest home/hospital and dementia care unit. Currently there are no rest home residents. The programme in the hospital includes group and one on one sensory activity that meet the resident's cognitive and physical abilities. The healthcare assistants (HCAs) include resident activities within their shift. The programme reflect activities that are meaningful and reflect ordinary patterns of life such as flower arranging, baking, gardening, shoe shining and household tasks. On the day of audit, residents in both units were observed participating in a variety of activities. Entertainment, outings and van drives are provided. Church services are held in the chapel on-site.</p>

		<p>Improvement is required around activity plans and activity plan reviews.</p> <p>Residents are able to provide feedback and suggestions for activities at the resident/family meetings and annual resident satisfaction survey (# link 1.2.3.6).</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>To hospital files evidenced six monthly review of the care plan. Two dementia care residents and one hospital resident had not been at the service long enough for a review.</p> <p>Three monthly multi-disciplinary reviews are completed by the registered nurse with input from health care assistants, the GP, and any other relevant person involved in the care of the resident. Family are invited by letter to attend. Three monthly clinical and medication reviews are conducted by the GP/NP.</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>The building has a current warrant of fitness that expires on 7 April 2015. There was a strong smell of urine in the dementia unit throughout the day of audit. An internal audit in September 2014 identified an issue around carpet cleaning (# link 1.2.3.8). The wet carpet cleaning machine has been out of order.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) use the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's and the laboratory that advise and provides feedback /information to the service.</p> <p>The service utilises the external benchmarking programme which analyses service data on a quarterly basis. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Infection control data is collated monthly and reported to the monthly quality meeting (# link 1.2.3.6). The meetings include the monthly infection control report and external bench marking quarterly results as available.</p> <p>All infections are documented on the infection monthly on line register. The surveillance of infection data assists in evaluating compliance with infection control practices.</p> <p>The service effectively managed a noro virus outbreak in March 2014 and relevant</p>

		authorities were appropriate informed.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	PA Low	<p>The PSC restraint minimisation and enabler use policy states that an enabler is the term applied to equipment such as bedrails, lap belts and harness, used to promote the independence, comfort and safety of the resident. The service's practice of the use of 'enablers' does not include a voluntary decision by the resident. There are 10 enablers in use (six bedrails and four lap belts). Four resident files with enablers (bedrails, lap belt and harness) were sampled. The residents were unable to make a voluntary decision regarding enablers and this therefore constitutes restraint under the 2008 restraint minimisation and safe practice standards. The service has an enabler coordinator and 'enabler' register. Documented enabler monitoring occurs for a period of two weeks then is documented in the progress notes each shift. However, entries in progress notes lack sufficient detail in regards to cares provided and specific monitoring interventions during the period of restraint. Enabler co-ordinators within the PSC group meet twice yearly and have telephone conference resources available. Restraint minimisation is included in the HCA study days.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There is an internal audit schedule, meetings calendar and education plan for 2014. A senior management team meeting is held monthly and discussion occurs around infections, resident clinical issues, quality issues, and policies for review. The range of meetings include: staff, senior management team, residents, health and safety, registered nurses and Eden Associates. These meetings and quality reports provide the means to measure achievement of the implemented quality and risk system. Monthly accident/incident</p>	<p>(i) Audits relating but not limited to challenging behaviour and enabler use have not been conducted as per the planner for 2014 and there has been no audits conducted in October and November. (ii) Staff meetings and residents meetings have not been conducted as per the planner for 2014. (iii) The senior team meets monthly however minutes for August 2014 only were available. (iv) There is no evidence that staff are informed regarding quality data. (v) There is no evidence that residents and relatives are informed regarding the satisfaction results of September 2013.</p>	<p>(i) Conduct internal audits as per schedule. (ii) Conduct meetings as per schedule. (iii) Produce minutes of meetings in a timely manner. (iv) Ensure that all quality data is reported back to staff and that data is available for staff to read. (v) Ensure that residents and relatives are informed regarding satisfaction results and that this is documented.</p> <p>90 days</p>

		reports are completed with collation of data and entry on to an electronic spread sheet, conducted by the quality coordinator. These are also compared with the previous months. External benchmarking indicator results (that includes analysis of manual handling injuries, skin tears, resident falls, resident accidents, medication errors, and staff accidents) has been conducted quarterly. The service has identified quality compliance issues and has initiated a quality systems process project 2014/2014 (November 2014).		
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>The quality monitoring programme (QMP) is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. The internal audit schedule has been combined to include QMP and external benchmarking monitoring. The policy for the service includes developing corrective action plans for audits with less than 85% compliance.</p>	<p>(i) There is no evidence that corrective action plans have been developed for audits in 2014 including nutrition (80%), pressure area (70%), pain assessment (75%), meaningful activity (71.6%), medication (76.75%) and carpet cleaning (80.9%). (ii) There is also no corrective action plan developed following the resident/relative satisfaction survey 2013.</p>	<p>(i) & (ii) ensure that all audits with less than 85% compliance and identified areas improvement following satisfaction surveys have correction action pans developed.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. There are comprehensive human resources</p>	<p>(i) Two staff files reviewed did not evidence up to date annual performance appraisals and one staff file did not evidence a signed job description. (ii) Three health care assistants working in the</p>	<p>(i) Ensure that all staff have an annual performance appraisal completed and all job descriptions are signed. (ii) Ensure that all health care assistance working in the</p>

		policies folder including recruitment, selection, orientation and staff training and development.	dementia unit have not completed the dementia specific modules within the required time frame and there is no evidence of one other health care assistant having commenced or completed the dementia specific modules.	dementia unit completed the dementia specific training within the required time frame. 60 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	There were standing orders in place signed by the contracted G.P.	The standing orders do not meet the Ministry of Health (MOH) guidelines for standing orders 2012.	Ensure the standing orders meet the MOH requirements. 90 days
Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	E4.3 One of two resident files reviewed identified current abilities, level of independence and identified needs and specific behavioural management strategies. D16.3k, Short term care plans are available to document changes in health status and interventions. The previous findings around care plan support/intervention remains.	(i) One dementia care resident does not have known potential behaviours identified in the care plan. One resident on behaviour monitoring does not have altered behaviour identified in the care plan. (ii) There is no short term care plan for one hospital resident with a 3kg weight loss.	(i) Ensure all known and altered behaviours are identified in the care plan. (ii) Ensure interventions for weight loss are documented. 60 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the	PA Low	The DT completes a lifestyle form with resident/family input as appropriate. An activity plan is developed and reviewed three monthly.	D16.5d In four of five resident files reviewed the individual activity plan is not reviewed at the same time as the care plan review. One hospital resident admitted October 2014 does not have activity assessment	Ensure activity plans are reviewed at the same time as the care plan. Ensure activity assessments and activity plans are completed within the required timeframes.

consumer.			or activity plan in place.	90 days
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	PA Low	<p>The service's practice of the use of 'enablers' does not include a voluntary decision by the resident. The decision for the use of 'enablers' is a clinical decision made by the nursing staff and with input from family. Consents, assessments and reviews are in place.</p>	<p>(i) The service has assessed and classified all residents with restraint as 'enabler's. This does not align with the 2008 restraint minimisation and safe practice standards. The decision for the use of 'enablers' has not been a voluntary decision for four hospital residents. The consent forms have been signed by the relative/EPOA. The reasons for use of 'enablers' for four hospital residents constitutes restraint. (ii) One hospital resident had a bed ladder in place which is documented in the care plan as enabling the resident to get up on the edge of the bed. There was no enabler documentation in place. (iii) Risks associated with the use of enablers/restraint are not identified in four of four care plans sampled.</p>	<p>Ensure that all residents with restraint are classified as such to align with current standards and best practice. The policy requires review to align with the current standards and best practice.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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

End of the report.