

Presbyterian Support Central - Brightwater Home

Introduction

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

The audit has been conducted by 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: 23 May 2016 End date: 24 May 2016

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: 48

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

General overview of the audit

PSC Brightwater Rest Home and Hospital is owned by Presbyterian Support Central and provide care for up to 63 residents at rest home, hospital and dementia level care. Occupancy on the day of the audit was 48 residents (two residents at rest home level care, 29 residents at hospital level care and 17 residents at dementia level care).

The service is overseen by a facility manager, who is a registered nurse and well qualified and experienced for the role. The facility manager is supported by two clinical coordinators and a regional operations manager. Residents interviewed spoke positively about the service provided.

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

This audit has identified the following areas requiring improvement; human resources, consumer information management, InterRAI assessments, care plan interventions, activities, dietary requirements, restraint documentation and infection control surveillance.

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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PSC Brightwater Home provides care in a way that focuses on the individual resident. There is a Māori Health Plan and cultural safety policy supporting practice. Cultural assessment is undertaken on admission. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are implemented to support residents' rights. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented, and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with the community.

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 low risk.
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PSC Brightwater Home is implementing the Presbyterian Support Services quality and risk management system. Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident and relative satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including

recruitment, selection, orientation, staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

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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The facility manager takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. A registered nurse completes initial assessments, including InterRAI assessments. The registered nurses complete the care plans and evaluations within the required timeframes. Care plans are based on the InterRAI outcomes and other assessments. They are clearly written and healthcare assistants report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. The bedrooms are all single and each have a hand basin and some rooms have ensuites. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

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.
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The service has documented policies and procedures for restraint minimisation and practice. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There were nine residents with restraints and four residents with enablers. There is a restraint coordinator for the service, who is the hospital clinical coordinator.

Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

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	41	0	9	0	0	0
Criteria	0	92	0	8	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Discussions with seven healthcare assistants (HCA), (four hospital and three dementia level) identified their familiarity with the Code of Rights. Interviews with 10 residents (two rest home and eight hospital) and eight family members (one rest home, four hospital and three dementia level) confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Seven resident files sampled (one rest home, three hospital, and three dementia level of care), demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>A policy describes access to advocacy services. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Interview with residents confirmed relatives and friends can visit at any time and they are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, relatives and residents confirm that residents are supported and encouraged to remain involved in the community and external groups.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a complaints policy to guide practice and this is communicated to residents/family. The facility manager leads the investigation and management of complaints (verbal and written). A complaint's register records activity and complaint forms are visible around the facility. There were two complaints documented in 2015 and five in 2016, year to date. Follow-up letters, investigation and outcome were documented. Two complaints documented in April 2016 have been followed up, but are yet to be resolved. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Code of Rights leaflets are available in the front entrance of the facility. Code of Rights posters are on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items not included in the scope.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p>	<p>FA</p>	<p>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of the PSC Brightwater Home facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident</p>

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		rooms. Residents and families interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service has access to a cultural advisor with links to local iwi, Tanenuiarangi Manawatu Incorporated. Specialist advice is available and sought when necessary. The service's philosophy results in each person's cultural needs being considered individually.
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	The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager and clinical coordinators, along with the resident and family/whānau complete the documentation. Regular reviews were evident and the involvement of family/whānau was recorded in the resident care plan. Residents and family interviewed feel that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. HCAs interviewed stated that there was a good culture within their team, even with the management changes occurring recently.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The service has a discrimination, coercion, exploitation and harassment policy and procedures in place. Code of Conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment. The Code of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured.
Standard 1.1.8: Good Practice Consumers receive services of	FA	The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend

<p>an appropriate standard.</p>		<p>orientation and ongoing in-service training. The resident satisfaction survey reflects satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p> <p>Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p>
<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>There is an open disclosure policy. Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve incident forms reviewed across the month of April 2016 identify family were notified following a resident incident. Interviews with healthcare assistants inform family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Discussions with residents and family members confirmed they were given time and explanation about services on admission. Resident meetings occur three times a year. Residents and relatives interviewed were positive about the care they receive.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>PSC Brightwater Home is part of the Presbyterian Support Central organisation (PSC) and provides rest home, hospital and dementia level of care for up to 63 residents. On the day of the audit, there were 48 residents in total; two of two rest home level residents, 29 of 37 hospital level residents and 17 of 24 residents in the secure dementia unit. The service has eight dual-purpose beds (two rest home and six hospital). There were three residents (hospital level) on the Young People with Disabilities (YPD) contract. All other residents were on the ARC contract.</p> <p>The facility manager at PSC Brightwater Home has over 20 years aged care experience and has been in the role for ten months. The facility manager is supported by two clinical coordinators. The clinical manager position has been vacant since Jan 2016. This position was recently filled and the clinical manager will take up the position in the next month.</p> <p>The clinical coordinator in the hospital wing has been in the role for one year. She has been at PSC Brightwater Home for 14 years. The clinical coordinator in the dementia wing has been in the position for seven months. She has been at PSC Brightwater Home for five years.</p> <p>PSC Brightwater Home has a 2015 – 2016 business plan and a mission and vision statement defined. The Business Plan outlines a number of goals for the year, each of which has defined objectives against quality and health and safety.</p> <p>The facility manager has maintained at least eight hours annually of professional development activities</p>

		related to managing a care facility.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the facility manager's absence, the hospital clinical coordinator undertakes the role and is supported by the regional manager and the Presbyterian Support Central (PSC) office. On the first day of audit, the facility manager was on leave and a facility manager from another PSC facility was on site providing management cover.</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>	FA	<p>PSC has an overall Quality Monitoring Programme (QMP) and participates in an external quarterly benchmarking programme, which is implemented at PSC Brightwater Home. The senior team meeting acts as the quality committee and they meet twice a month. Information is fed back to the monthly clinical focused meetings and unit staff meetings. There is a range of other meetings held at the facility. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms, which are being signed off and reviewed for effectiveness (link 3.5.7 around infection control surveillance). The regional manager has provided oversight and support to the management team weekly.</p> <p>Progress with the quality programme/goals was monitored and reviewed through the monthly senior team meetings. The internal audit schedule has been combined to include QMP and external benchmarking monitoring. Feedback on monthly accidents and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the quality and staff meetings. The service has a health and safety management system and this includes a health and safety representative that has completed health and safety training. Health & safety meetings include identification of hazards and accident/incident reporting and trends.</p> <p>The service has policies and procedures to provide 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. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The facility manager is responsible for document control within the service; ensuring staff are kept up to date with the changes. A resident satisfaction survey is completed annually. The 2015 survey informed an overall satisfaction with the service for residents at 57% and an overall satisfaction with the service for relatives at 81%. Corrective actions were developed to address these results. The service advised they did not re-</p>

		survey following implementation of the corrective actions.
<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>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. 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>Senior team meetings and clinical focused meeting minutes include analysis of incident and accident data and corrective actions. A monthly incident/accident report is completed which includes an analysis of data collected. This is provided to staff. All identified follow-up assessments by a registered nurse include neuro observations for those residents that had a fall and hit their head. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>Nine section 31 incident notification forms were completed in 2015 and 2016 (all sighted). There were three matters referred to the police and four matters relating to health and safety and one pressure area. One of the police investigations is still open.</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>	PA Low	<p>A human resources policies folder includes recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Nine staff files were reviewed (one clinical coordinator, one registered nurse, three healthcare assistants, one cook, one diversional therapist, one maintenance person and one cleaner). Each folder had a file checklist and documentation arranged under personal information, correspondence, agreement, education and performance appraisals. The service has an orientation programme in place.</p> <p>Copies of qualifications and annual practising certificates including registered nurses and general practitioners and other registered health professionals are kept. A training programme is implemented that includes eight hours annually. The registered nurses and care staff attend PSC professional study days that cover the mandatory education requirements and other clinical requirements. The staff-training plan includes regular sessions occurring as per the monthly calendar. The registered nurses have a journal club that encourages ongoing learning and sharing. Eighteen HCAs work in the dementia unit. Not all HCAs working in the dementia unit have completed the required dementia unit standards training.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster in place provides sufficient and appropriate coverage for the effective delivery of care and support. There is at least one registered nurse on duty at all times. The facility manager works full time, Monday to Friday. Casual staff are available to cover staff illness. There is designated staff for kitchen, laundry, cleaning and activities. The facility manager shares the 24/7 clinical duties with the support of the clinical coordinators for clinical and the administrator for non-clinical issues.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Not all amendments to care plans were signed and dated with a designation recorded.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager and clinical coordinators. The admission agreement form in use aligns with the requirements of the ARC contract.</p> <p>Written information on the service philosophy and practices particular to dementia care, (including minimisation of restraint, behaviour management and the complaints policy) are included in the information pack.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Fourteen medication files were sampled (two rest home, six hospital including one resident admitted under a young person with disability contact and six dementia level care). The service uses an electronic medication management system. The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Residents' medicines are stored securely in the medication room/cupboard. Medication administration practice complies with the medication management policy for the medication round sighted. Registered nurses administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was evidence of three monthly reviews by the GP. One resident self-administers their own medicines, and the documentation was correctly recorded and a competency assessment completed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Low</p>	<p>There is a fully functional kitchen and all food is cooked on site. There is a food-services manual in place to guide staff. The kitchen manager advised that a resident nutritional profile is developed for each resident on admission; however, nutritional profiles were not available in the kitchen for all residents. The kitchen staff did not know all residents' food allergies. The nutritional profile is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. There was evidence that there are additional nutritious snacks available over the 24-hour period in the secure dementia units.</p> <p>All kitchen staff have completed food safety training.</p> <p>The kitchen follows a rotating seasonal menu, which was reviewed in April 2015 by an external dietitian. Refrigerators, freezers and cooked food temperatures are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by</p>	<p>FA</p>	<p>The service records the reasons for declining service entry should this occur and communicates this decision to family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is provided.</p>

the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Seven files sampled indicated that all appropriate personal needs information was gathered during admission, in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and reviewed, when there was a change to a resident's health condition. Care plans sampled were developed based on these assessments. The InterRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Not all InterRAI assessments had been reviewed six monthly (link 1.3.3.3).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Five of seven long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings (link 1.3.6.1). The InterRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed, reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status (link 1.3.8.2). Resident documentation includes Eden Alternative philosophy. Staff interviewed reported they found the care plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	Registered nurses (RNs) and HCAs, follow the care plan and report progress against the care plan at each shift handover. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse [hospice nurse] or the mental health nurses). If external medical advice is required, this will be actioned by the GPs or nurse practitioner. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described. Wound management plans were fully documented for all current wounds; however, the wound re-assessments were not fully documented with each dressing change. There were four wounds present on the day of audit. In the hospital, there was one non-facility acquired pressure injury, one skin tear and one chronic lesion. In the dementia area, there was one chronic lesion. There were no wounds at rest home level of care. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service and their nurse practitioner. Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions did not always document the interventions in sufficient detail to guide

		<p>the care staff. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. Not all monitoring charts had been consistently documented.</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>One diversional therapist and two recreation officers are employed to operate the activities programme for all residents. The service has achieved seven Eden principles. The programme operates seven days a week. The programme is supported by a team of volunteers who drive the van, help with the gardening and craft groups, and provide general support to the programme, including delivery of the programme in the weekends.</p> <p>An activities assessment is completed on admission, in consultation with the resident/family (as appropriate), which is incorporated into the InterRAI assessment process. An activities section in the resident file includes an activities assessment, life experiences care and an activity care plan. The activity care plan includes comfort and wellbeing, outings, interests and family, and community and entertainment. The documentation in the resident activity care plan did not always reflect the uniqueness and needs of each resident.</p> <p>Activities are generally conducted in the lounges for the rest home and hospital residents, or the two smaller lounges in the dementia unit.</p> <p>Residents are free to choose to participate in the group activities programme or their individual plan. Participation is monitored. There is a set activity programmes for the three different levels of care that is resident focused and is planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, dusting, tidying drawers and making own beds (if able). All residents can be involved in gardening and pets are welcomed as part of the home environment and the Eden Philosophy of care. The dementia files reviewed did not evidence a 24-hour activity care plan.</p> <p>All long-term resident files sampled have an activities plan within the care plan, however this was not always reviewed six monthly when the care plan is evaluated.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six monthly or earlier if there is a change in health status. There was at least a three monthly review by the GP. All changes in health status were documented and followed up. Re-assessments have been completed using InterRAI LTCF for all residents who have had a significant change in health status since 1 July 2015 (link 1.3.3.3). The RN completing the plan signs care plan reviews. Where progress is different from expected, the service responds by initiating changes to the care plan (link 1.2.9.9). Overall, short-term care plans sighted were</p>

		evaluated and resolved and added to the long-term care plan where the problem was ongoing (link 1.3.6.1).
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were stored safely throughout the facility. Safety data sheets are available.
<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	The building has a current building warrant of fitness that expires in April 2017. PSC have invested significantly in upgrades in the past two years, including upgrading the dementia area gardens, refurbishment of resident bedrooms, replacing flooring, furniture and curtains, and installing new heating and cooling systems. The maintenance manager undertakes the reactive maintenance and works 40 hours per week. The maintenance manager also looks after the grounds and is available afterhours for emergencies. Scheduled maintenance is arranged and managed through PSC head office. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in

		<p>the resident care plans.</p> <p>The secure dementia outdoor area is easy to access and is well maintained. There are also quiet low stimulus areas that provide privacy when required.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have ensuites and other residents share communal toilets and showers. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large central dining room for the rest home and hospital residents. There are several lounge areas and sitting rooms in the hospital and rest home. The dementia unit has one large lounge and a smaller sunny lounge area that overlooks the internal courtyard. There is a separate dining area and activity area.</p> <p>There is adequate space throughout the facility to allow maximum freedom of movement while promoting safety for those that wander. There is adequate space to allow for group and individual activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with</p>	FA	<p>Dedicated cleaning staff are rostered on to clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.</p>

<p>safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>Dedicated laundry staff complete all laundry on site in an appropriately appointed laundry. Residents interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and</p>	<p>FA</p>	<p>PSC Brightwater has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the infection control coordinator. The infection control coordinator has support from all staff including the quality management committee (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>

scope of the service.		
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control coordinator is a registered nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising all staff) have good external support from the PSC clinical director and PSC clinical nurse practitioner, and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are PSC infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has a level seven infection control qualification. The infection control coordinator attends monthly infection control forums held at the DHB. Visitors are advised of any outbreaks of infection and are recommended not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p>
Standard 3.5: Surveillance	PA Low	<p>Infection surveillance is an integral part of the infection control programme and described in the PSC infection control manual. Monthly infection data is collected for all infections based on signs and</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>symptoms of infections. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. Analysis and trending of the infection control data is not consistently occurring. Outcomes and corrective actions are not consistently communicated at staff and quality meetings. An outbreak of norovirus in August 2015 had corrective action plans documented that have not yet been completed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The organisational policy for restraint minimisation and enabler use ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register.</p> <p>On the day of audit, there were nine residents with 11 restraints (six bed rails and five lap belts) and four residents with five enablers (4 bed rails and one fixed belt). Documentation was reviewed for five hospital residents using a restraint and three residents on enablers (two hospital and one young person with disability). Restraint minimisation and challenging behaviour training was completed in December 2015 and 18 staff attended.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint coordinator is a registered nurse and has a signed job description and understands the role and her accountabilities. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or family/whānau representative and medical practitioner.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>PA Low</p>	<p>The service completes comprehensive assessments in partnership with the resident, their family/whānau and the medical officer for all residents who are being considered for the use of restraint or enablers. Restraint assessments are based on information in the care plan, resident/family whānau discussions and on observations by the staff. Not all residents using a restraint had their restraint assessments fully documented.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>PA Low</p>	<p>The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. An assessment form/process is completed for all restraints and enablers (link 2.2.2.1).</p> <p>Care plans reviewed, of residents with restraints and enablers, did not all include specific interventions to manage the identified risks. Monitoring forms were not all fully completed. The service has restraint and enablers registers that are updated each month.</p> <p>Restraint use is reviewed through the three monthly assessment evaluation, monthly restraint meetings and six monthly multidisciplinary meeting and includes family/whānau input (link 2.2.4.1).</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The service has documented evaluation of restraint every three months. Where three monthly evaluations had been completed, there was evidence that the evaluations had been completed with the resident, family/whānau and restraint coordinators. Restraint practices are reviewed on a formal basis every month by the restraint coordinators at quality meetings. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three monthly or sooner if a need is identified. The restraint coordinator monitors restraint usage. The restraint coordinator reviews relevant Incidents/accidents. Any adverse outcomes are reported at the monthly quality and health and safety meetings.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	All staff working in the dementia unit are required to comply with the dementia specific training requirements outlined in the ARRC agreement. Not all healthcare assistants who are working in the dementia unit have completed the required unit standards within the required timeframes.	Seven out of eighteen HCAs who have been working in the secure dementia unit for more than 12 months have not completed the required dementia unit standards.	<p>Ensure that all staff working in the secure dementia unit complete the required dementia specific training within the required timeframes.</p> <p>90 days</p>
<p>Criterion 1.2.9.9</p>	PA Low	The registered nurse makes alterations and additions to the long-term care plans if	Seven of seven long-term care	Ensure that all amendments

<p>All records are legible and the name and designation of the service provider is identifiable.</p>		<p>there is a change to the health status. Not all additions or amendments were dated or signed with a designation recorded.</p>	<p>plans (one rest home, three hospital and three dementia) did not have amendments or alterations consistently dated and signed with a designation recorded.</p>	<p>and alterations to the long-term care plans are consistently signed and dated with a designation documented.</p> <p>90 days</p>
<p>Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.</p>	<p>PA Low</p>	<p>The registered nurses complete a nutritional assessment as part of the admission process and provide a copy of this information to the kitchen. Not all nutritional assessments, including information about residents with food allergies had been provided to the kitchen.</p>	<p>i) Three dementia residents recently admitted, did not have a nutritional profile sent to the kitchen.</p> <p>ii) The kitchen staff were unaware of one hospital resident with a food allergy.</p>	<p>i-ii) Ensure that the kitchen receives a copy of the nutritional profile for all residents and the kitchen is advised of any resident food allergies.</p> <p>60 days</p>
<p>Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>A sample of seven clinical records was reviewed (one rest home level of care, three hospital level of care including one resident admitted on a young person with disability contract and three dementia level care). Registered nurses complete initial</p>	<p>Three of seven files sampled (dementia level care) had not had the InterRAI assessment</p>	<p>Ensure that assessments are reviewed with a change in health condition or</p>

		<p>assessments within 24 hours of admission and initial care plans were implemented. InterRAI assessments reviewed have been completed within 21 days of admission and long-term care plans reviewed were completed within three weeks of admission. Care plans reviewed have been evaluated by a registered nurse and amended when the residents' health changes. Residents have further InterRAI assessments when their health needs change.</p> <p>The InterRAI assessment tool is used to inform the development of the care plan. Not all InterRAI assessments had been reviewed six monthly.</p>	<p>reviewed six monthly.</p>	<p>reviewed at least six monthly.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>The registered nurses interviewed confirmed that interventions are documented in the care plan for all assessed care needs. However, in the files sampled, interventions for all assessed care needs had not been documented. Monitoring records were in place however not all required monitoring was consistently documented. Wound management plans were fully documented for all current wounds, however the wound re-assessments/progress were not fully documented with each dressing change.</p>	<p>(i) Two of seven care plans reviewed (one hospital, one dementia), did not include all interventions to address assessed needs.</p> <p>(ii) De-escalation strategies were not fully documented for one dementia resident with abusive behaviour.</p>	<p>i-iii) Ensure that interventions are fully documented to meet the assessed care needs of the residents.</p> <p>iv) Ensure that all required monitoring is consistently documented.</p> <p>v) Ensure that all wound documentation is fully</p>

			<p>(iii) One dementia resident on a short-term care plan for behaviour, had not had the interventions evaluated or transferred to the long-term care plan.</p> <p>(iv) Monitoring records were not consistently documented for one hospital resident on two hourly turns.</p> <p>(v) The initial wound assessment for one hospital resident did not fully describe the wound.</p> <p>(vi) Four of four wounds (three hospital - including hospital tracer and one dementia), did not document the wound healing/progress with each</p>	<p>completed.</p> <p>90 days</p>
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			dressing change.	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>The recreational programme offered in the dementia unit is varied and interesting and each resident has an individualised programme. The dementia resident files reviewed did not evidence an activity plan that covered the 24-hour period. The activity plans had not all been evaluated six monthly and the evaluations when completed, were not reviewed against the stated goals. One visually impaired resident had not had activities planned or documented, to meet their needs.</p>	<p>i) Three of three resident files sampled for residents in the secure dementia unit, did not have activity plans documented to cover the 24-hour period.</p> <p>ii) One of seven activity care-plans (hospital – young person with disability) had not been reviewed six monthly.</p> <p>iii) Seven of seven activity care-plans (one rest home, three hospital and three dementia) had not been evaluated against the stated activity goals.</p> <p>iv) One dementia activity</p>	<p>i) Ensure that all residents in the secure dementia unit have a 24-hour activity care plan documented.</p> <p>ii) Ensure that activity plans are reviewed at least six monthly.</p> <p>iii) Ensure that the activity care plan is reviewed against the stated goals.</p> <p>iv) Ensure that activities are planned and documented to meet the specific needs of the resident.</p> <p>90 days</p>

			plan had no activities documented to meet the specific needs of a resident with visual impairment.	
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	PA Low	<p>Infection control data is recorded each month, however this information is not consistently trended or communicated to staff. The corrective action plan developed during the outbreak in August 2015 has not yet been completed.</p>	<p>i) Infection control data is recorded monthly, however month-on-month trending and analysis of this data was not consistently evidenced.</p> <p>ii) The surveillance data was not consistently communicated to all staff.</p> <p>iii) The corrective action plan developed during the norovirus outbreak in August 2015 has not yet been completed and</p>	<p>i-ii) Ensure that infection control data is consistently trended and analysed and the results are consistently communicated to all staff.</p> <p>iii) Ensure that the corrective action developed during the norovirus outbreaks is completed and signed out.</p> <p>90 days</p>

			signed out.	
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p> <p>(h) Possible alternative intervention/strategies.</p>	PA Low	The service completes an assessment for residents who are being considered for the use of restraint or enabler interventions. Not all residents using a restraint had their assessments fully documented.	Two of five hospital restraint files reviewed did not have their restraint assessments fully documented.	<p>Ensure that all assessment forms for residents on restraint are fully completed.</p> <p>60 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p>	PA Moderate	The registered nurse and/or the restraint coordinator, document restraint and enabler use care plans. Not all residents using a restraint or an enabler had interventions documented to manage the identified risks. Not all monitoring of residents using a restraint was consistently documented	i) Four of five hospital residents using a restraint, and three of three residents using enablers (two hospital and one young person with disability), did not have interventions documented to manage all	i) Ensure that interventions are documented, to cover the risks associated with the use of the restraint or enablers and the residents care requirements whilst using

<p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>			<p>identified risks.</p> <p>ii) Five of five hospital residents using restraint did not have the required monitoring consistently documented.</p>	<p>the restraint or enabler, are fully documented.</p> <p>ii) Ensure that all monitoring whilst using a restraint is consistently documented.</p> <p>60 days</p>
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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.

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End of the report.