

# Presbyterian Support Central - Brightwater Home

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## Introduction

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

The audit has been conducted by 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); Dementia care

**Dates of audit:** Start date: 1 December 2017 End date: 1 December 2017

**Proposed changes to current services (if any):** Since the last audit, six rooms have been decommissioned and are now used for staff and family accommodation.

**Total beds occupied across all premises included in the audit on the first day of the audit: 54**



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

PSC Brightwater Rest Home and Hospital is owned by Presbyterian Support Central and provide care for up to 57 residents at rest home, hospital and dementia level care. Since the last audit, six rooms have been decommissioned and are now used for staff and family accommodation. Occupancy on the day of the audit was 54 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and general practitioner.

The facility manager at PSC Brightwater Home has over 10 years change management experience and has been in the role for one year. The facility manager is supported by a clinical nurse manager, clinical coordinator and a regional manager. Residents interviewed spoke positively about the service provided.

The service has addressed eight of the nine shortfalls from the previous certification audit relating to human resources, consumer information management, interRAI assessments, care plan interventions, dietary requirements, restraint documentation and infection control surveillance. An improvement continues to be required in relation to activity care plans.

This audit has identified further improvements required relating to the complaints process and hazard register.

## 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.		Some standards applicable to this service partially attained and of low risk.
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PSC Brightwater Home provides care in a way that focuses on the individual resident. The service ensures effective communication with all stakeholders including residents and families. There is a complaints policy to guide practice and this is communicated to resident/family.

## 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to individual and group activities. The group programme (which is available for rest home, hospital and dementia residents) is varied and interesting. There are medicine management policies and procedures in place. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on-site and the menu has been reviewed by 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

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building has a current warrant of fitness.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had two residents using enablers and five residents assessed as requiring the use of restraint.

## 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.
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The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are evaluated and reported to relevant personnel.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	17	0	2	1	0	0
<b>Criteria</b>	0	39	0	2	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>There is a complaints policy to guide practice and this is communicated to resident/family. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaint register that records activity. Complaints are discussed at the monthly senior management team meeting and the monthly staff meetings. Information on making a complaint and the forms are visible around the facility. There were ten complaints made between May 2016 and November 2017; however, four complaints reviewed did not have documented evidence that the complaint had been resolved or closed off. Discussion with residents and relatives confirmed they were aware of how to make a complaint.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The service has an open disclosure policy. Discussions with seven residents (five hospital and two rest home) and two family members (two dementia care) confirmed they were given time and explanation about services and procedures on admission. There are six-monthly meetings held with relatives. The facility manager, clinical nurse manager and clinical coordinator have an open-door policy. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve accident/incident forms reviewed identify that family were notified following a resident incident. Interviews with three registered nurses (RN), one enrolled nurse (EN), one clinical coordinator and two managers confirmed that family members are kept informed. Interpreter services are available.</p>

conducive to effective communication.		
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<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. Since the last audit, six rooms have been decommissioned and are now used for staff and family accommodation. On the day of the audit, there were 54 residents in total (five rest home level residents including one resident on a younger persons with disabilities (YPD) contract and one resident on a long term support chronic health condition (LTSCHC) contract; 26 hospital level residents, including one resident on a YPD contract; and 23 of 24 dementia level residents in the secure dementia unit. The service has eight dual-purpose beds. All other residents were on the aged related residential care (ARRC) agreement.</p> <p>The facility manager at PSC Brightwater Home has over 10 years change management experience and has been in the role for one year. The facility manager is supported by a clinical nurse manager, clinical coordinator and a regional manager. The clinical nurse manager has been in the position for 16 months. The clinical coordinator has been in the role for one year. She has been at PSC Brightwater Home for six years.</p> <p>PSC Brightwater Home has a 2017–2018 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 and clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a care facility.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>Presbyterian Support Central has an overall quality monitoring programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. 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 staff meetings. A range of other meetings is 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. The facility manager had an understanding of the contractual agreements and requirements. The regional manager provides oversight and support to the facility manager.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2016 and 2017 (year to date). Quality data and analysis is shared with staff (placed on noticeboards) and corrective actions are signed out and evaluated for effectiveness. The service has a health and safety management system and this includes a health and safety rep that has completed health and safety training. Monthly reports are completed and reported to meetings and at the bi-monthly Health and Safety Committee meeting. There is a hazard register, however the register had not been reviewed annually. A falls prevention programme is in place that includes the</p>

		<p>analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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 and relative satisfaction survey is completed annually. The 2016 relative satisfaction survey confirmed a satisfactory result with the service. Corrective actions were developed to address any concerns from the survey. The 2017 relative satisfaction survey had not been completed due to recent staff changes.</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>	FA	<p>The service collects incident and accident data and reports aggregated figures monthly to the quality meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of event and the form is forwarded to the clinical nurse manager for final sign off. A sample of twelve resident related incident reports (six hospital, three rest home and three dementia level) were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. Reports were completed and family notified as appropriate. There is an incident reporting policy to guide staff in their responsibility around open disclosure. The HCAs interviewed could discuss the incident reporting process. Discussions with the facility manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications and evidence of this occurring was sighted on audit. Two section 31 notifications were submitted to the Ministry of Health in July 2016 and September 2017. Both of the matters referred to coroner inquests and were subsequently closed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	FA	<p>There are human resource management policies in place, which include recruitment. Staff process requires that relevant checks are completed to validate the individual's qualification, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (one clinical nurse manager, one clinical coordinator, one RN, one recreation officer and two HCA's). All files contained employment agreements and job descriptions. A schedule had been put in place to catch up and maintain annual performance appraisals. Outstanding annual appraisals had been completed and the 2017 performance appraisal schedule was being adhered to. The service is using the PSC recently introduced orientation programme that provides new staff with relevant information for safe work practice.</p> <p>The in-service education programme for 2017 is being implemented. Staff attend annual compulsory study days</p>

<p>practice and meet the requirements of legislation.</p>		<p>which includes training around the Eden Alternative programme. The clinical coordinators and RN's are able to attend external training. Eight hours of education or in-service education has been provided annually. All individual records and attendance numbers are maintained. A schedule of which staff have attended education is maintained and follow-up action and sessions are offered to ensure all staff receive the required training. Five of seven RNs are interRAI trained. There are thirteen HCAs on the roster in the dementia unit and six have completed the required dementia standards, three are in progress of completing and four have not completed. The four HCAs that have not completed have all commenced within the last six months. This previous finding has now been addressed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse manager work full-time, Monday through to Friday. The facility manager is on call for any non-clinical matters and the clinical nurse manager is on call for any clinical issues. Interviews with HCA's, residents and family members identify that staffing is adequate to meet the needs of residents.</p> <p>In the Tui unit, there are 17 residents (3 rest home and 14 hospital level residents) and Heron unit, 14 residents (2 rest home and 12 hospital). There is a clinical coordinator who is supported by an RN on the morning, afternoon and night shifts. There are six HCA's on the morning shift and on the afternoon shift and two HCAs on the night shift.</p> <p>In the Kiwi (dementia) unit, there are 23 residents. There is a RN on the morning, afternoon and night shifts. There are three HCA's on the morning shift and on the afternoon shift and one HCA on the night shift.</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>	<p>FA</p>	<p>All amendments and alterations to the long-term care plans have been signed and dated with a documented designation. This previous finding had now been addressed.</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>Ten medication charts were reviewed (two rest home, five hospital - including one YPD and three dementia). There are policies available for safe medicine management that meet legislative requirements. All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed all resident's medication three-monthly and all known allergies were noted. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided.</p> <p>Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service uses an electronic charting and administration recording system and blister packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. There are no standing orders in use and there were no residents self-medicating on the day of audit. The medication fridge temperatures are recorded regularly and these are within acceptable ranges.</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>All meals at PSC Brightwater are prepared and cooked on-site. There is a five-weekly seasonal menu which had been reviewed by a dietitian. A portable bain marie is used to deliver foods to the dining rooms where they are served by the cook. End cooked and holding food temperatures are recorded. Fridge and freezer temperatures are recorded. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. The kitchen has a nutritional profile and list of any food allergies for all residents. This previous finding has now been addressed.</p> <p>Nutritious snacks are available 24-hours a day for residents in the dementia unit. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes. All food services staff have completed training in food safety and hygiene and chemical safety.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	<p>FA</p>	<p>When a resident's condition alters, the clinical nurse manager, clinical coordinator or RN initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health. In the residents' files reviewed, short-term care plans were commenced with a change in health condition and if not resolved within three weeks, transferred to the long-term care plan. Interventions were fully documented to meet the residents' assessed needs. This previous finding has now been addressed. Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified.</p>

<p>assessed needs and desired outcomes.</p>		<p>Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP and wound care specialist nurse involvement in wounds. On the day of audit, there was one facility-acquired stage II pressure injury. The wound care files sampled evidenced that the wound care documentation (assessments, management plans and evaluations) were fully completed and this is an improvement on the previous audit.</p> <p>Registered nurses were able to describe access for wound and continence specialist input as required. Dressing supplies were sighted and on the day of audit, there were five wounds in the hospital (one pressure injury, one skin tear, one burn, one allergic reaction and one lesion). In the dementia unit, there was one resident with a lesion. Behaviour monitoring forms are used (sighted) which described types of behaviour, possible triggers and the strategies for de-escalation that were used. The monitoring charts are reviewed by the RN. The GP, clinical nurse manager or clinical coordinator initiates specialist referrals to the mental health services.</p> <p>Other monitoring charts were in use including (but not limited to); food and fluid, weight loss, and turning charts.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Moderate</p>	<p>The recreational team provide individual and group activities in the rest home, hospital and dementia care units seven days per week. The recreation programme is supported by a team of volunteers. The recreational programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The residents were observed participating in group and individual activities during the audit. Participation in the group programmes is voluntary. There are regular outings/drives for all residents (as appropriate) and involvement in community events. One-on-one activities occur for residents who are unable or choose not to be involved in activities. The programme is displayed on noticeboards in all units.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate) and a recreational plan is developed. Where recreational plans were sighted, these had been reviewed six-monthly at the same time as the care plans. Activity plans were reviewed six monthly as part of the care plan evaluation and review to determine goals were being addressed and plans were specific to the identified needs of the individual resident. This is an improvement on previous audit. In the dementia files sampled, the recreational plans did not cover the 24-hour period. The previous audit finding relating to lack of a 24-hour recreational plan for each resident in the dementia unit remains. The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. This includes from the YPD clients who have a number of individualised activities. Relatives and residents stated they were satisfied with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>The RNs evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan is 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. Reassessments have been completed using interRAI LTCF (except for YPD) and</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>other relevant assessment tools for residents who have had a significant change in health status. Short-term care plans were in use and evidence showed that after three weeks if the issue had not been resolved, transfer was made to the LTCP.</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>	<p>FA</p>	<p>The building holds a current building warrant of fitness, which expires 7 April 2018.</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>Click here to enter text</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</p>	<p>FA</p>	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and loaded into the PSC electronic system. Data is analysed monthly to identify areas for improvement. Benchmarking occurs between the facilities and data is forwarded to the site for corrective actions to be undertaken if required. Information is fed back to staff. This previous finding has now been addressed. Two projects had been undertaken on reducing cellulitis and eye infections. This included educating staff on both conditions and the prevention of. Infection control internal audits are included in the annual audit schedule. Trends are identified and quality initiatives are discussed at staff meetings. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks since the previous audit.</p>

control programme.		
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>PSC Brightwater has policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The clinical nurse manager is the restraint coordinator with a job description defining responsibilities of the role. There are five residents assessed as requiring restraint (lap belts and/or bedrails are used). There were two residents using enablers (lap belt and bedsides). The two enabler files reviewed evidenced assessment, risks of use, consent and evaluation of use. Enablers in use were voluntary. A programme of reducing the use of restraints was in place (evidence in clinical meeting minutes October 2017). The service has focused on reducing the use of restraint by a number of strategies including the purchase of additional sensor mats and more regular reviewing of restraint. Strategies were successful and the safe discontinuation of five restraints had recently occurred.</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>	FA	<p>Restraint assessments are based on information in the care plan, resident/family whānau discussions and on observations by the staff. All five restraint files reviewed evidenced fully completed assessment forms. There was documentation of interventions in all files reviewed to managing risks associated with the restraint in use. This previous finding has now been addressed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>All files reviewed evidenced the risks of use of the restraint or enabler were documented in the assessment and there transferred to care plan interventions. All monitoring whilst using a restraint was consistently documented in the five files reviewed. This previous finding has now been addressed.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	The facility manager leads the investigation and management of complaints (verbal and written). There is a complaint register that records activity. There were ten complaints made between May 2016 and November 2017. However, four complaints reviewed did not have documented evidence that the complaint had been resolved or closed off.	Ensure that all complaints made have documented evidence of resolution or close off.	<p>Ensure that all complaints made have documented evidence of resolution or close off.</p> <p>90 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified,</p>	PA Low	The service has a health and safety management system and this includes a hazard register, however,	The hazard register had not been reviewed	Ensure that the hazard register is

<p>documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>the register has not been reviewed annually.</p>	<p>annually. There was no documented evidence of hazard identification form for 2017 being updated on the hazard register.</p>	<p>reviewed annually and that hazard identification forms are updated on the hazard register.</p> <p>90 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>The recreation officers complete the activity profile and 'tree of life' when the resident is admitted, in consultation with the resident and their family (as appropriate). A recreational plan is then developed for each resident and this is reviewed in conjunction with a review of the long-term care plan. There are separate group programmes for each service level and the residents can also join in the activities that are provided by the day programme (on three days of the week). The YPD residents had a number of individual activities that they were encouraged with, along with remaining in contact with the community. Residents in the dementia unit did not have a recreational plan documented for the 24-hour period.</p>	<p>One of one resident files sampled in the dementia unit did not have a 24-hour recreational plan documented. On interview with the recreation officers and RNs, it was confirmed no residents in the dementia unit had a recreational plan for a 24-hour period.</p>	<p>Ensure that all residents in the dementia unit have a 24-hour recreational plan documented.</p> <p>60 days</p>

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

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

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

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

No data to display
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End of the report.