

Presbyterian Support Central - Brightwater Home

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 BSI Group New Zealand Ltd, 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: 24 March 2021 End date: 24 March 2021

Proposed changes to current services (if any): The service has been verified as suitable to provide residential disability – physical level of care.

Total beds occupied across all premises included in the audit on the first day of the audit: 51

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

Brightwater Home is owned by Presbyterian Support Central (PSC) and currently provides care hospital, rest home and dementia level care for up to 58 residents. Occupancy on the day of the audit was 51 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services 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 the general practitioner.

The service is overseen by an experienced facility manager who is a registered nurse and manages the two local PSC facilities. The facility manager is supported by a clinical nurse manager, clinical co-ordinator, registered nurses and long-serving staff. Residents, family and the general practitioner interviewed spoke positively about the service provided.

The service has applied to HealthCERT to provide residential disability-physical level care. This service has been verified as suitable to provide residential disability – physical level care as part of this audit.

Two of three previous audit shortfalls have been addressed around open disclosure and neurological observations.

There continues to be shortfall around the quality programme.

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 endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. The service promotes and encourages open communication. There is evidence that residents and family are kept informed on facility matters and clinical concerns.

Complaints and concerns processes are in place and managed within the required timeframes. The complaints procedure and Enliven complaint forms are available at the entrance to the facility.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is a documented quality and risk system in place. Key components of the quality management system link to monthly senior team and staff meetings and to relevant personnel at head office. Quality data is reviewed at head office and benchmarking results are fed back to the service. 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 in place. 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.		Standards applicable to this service fully attained.
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Assessments, planning and evaluation of residents' needs, outcomes and goals is undertaken by the registered nurses with the resident and/or family/whānau input. Care plans viewed in resident electronic records demonstrated service integration. Resident files included medical notes by the general practitioner and visiting allied health professionals. There is a three-monthly general practitioner (GP) review.

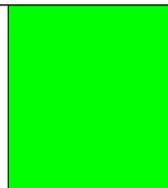
The activities programme provides diversional therapy activities that meet the cognitive and physical abilities of the residents for all levels of care. The programme is varied and include one to one and group activities, community involvement and outings.

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 qualified chef. The menu has been approved by a dietitian. Individual and special dietary needs are catered for. There are nutritious snacks available 24 hours. 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.

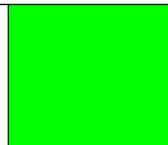


Standards applicable to this service fully attained.

Brightwater Home has a current building warrant of fitness. There is a reactive and planned maintenance plan in place. Residents can freely access communal areas using mobility aids. There are communal dining areas, craft and recreational areas, and several lounges and seating areas. Outdoor areas and the internal courtyards are safe and accessible for the residents. The dementia wing is secure and offers outdoor space and a walking pathway.

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.

Brightwater Home has restraint minimisation and safe practice policies and procedures in place which state the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort.

The clinical nurse manager is the restraint and enabler coordinator. At the time of the audit there were seven residents using restraint and one resident using an enabler (voluntarily requested). Staff receive training in restraint minimisation and challenging behaviour management which is included in the training programme.

Infection prevention and control

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

Standards applicable to this service fully attained.

The type of infection surveillance is appropriate to the size and complexity of the service. The clinical co-ordinator is the infection control nurse. Infection events are collated monthly and analysed for trends and areas for improvement. Information obtained through surveillance to determine infection control activities and education needs within the facility. Monthly surveillance data is reported to staff at meetings.

There have been no outbreaks since the previous audit. Adequate supplies of personal protective equipment were sighted.

Covid19 is well managed, and there was additional education, communication and screening during Covid-19 restrictions.

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	15	0	1	0	0	0
Criteria	0	40	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice in line with Rights 10 of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written) in consultation with business operations manager at head office. An online complaint register is maintained and includes: the date the complaint is received; the category of complaint and a summary of the complaint; the date of meeting/discussion; and the date the complaint was closed/resolved. Enliven concern/complaint forms and advocacy brochures are visible at the main entrance.</p> <p>Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the Enliven concern/complaint forms and advocacy brochures are provided to residents within the information pack at entry. Clinical staff interviewed (four healthcare assistants (HCAs), one recreation officer one clinical nurse manager and the facility manager) were knowledgeable around the complaints procedure.</p> <p>There have been two complaints since the previous audit (two in 2020 and nil in 2021). A review of complaints identified that these had been investigated promptly and issues resolved in a timely manner for one complaint.</p> <p>There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.</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 that sets out the process to guide staff and ensure that there is open disclosure of any adverse event where a resident has suffered unintended harm while receiving care.</p> <p>The prospective resident information brochure and the welcome pack for new residents include all required information for residents and family. The resident admission agreements are signed by the resident or enduring power of attorney (EPOA).</p> <p>The monthly residents' meetings inform residents of facility events and activities and provide attendees with an opportunity to: make suggestions; provide feedback; and to raise and discuss issues or concerns. These meetings were held regularly in 2019 but were disrupted in 2020 due to Covid-19.</p> <p>Three residents (two rest home and one hospital) and two relatives (one hospital and one dementia care) interviewed, stated they were welcomed on entry and were given time and explanation about the services and charges not included in the admission agreement. The facility manager and clinical nurse manager operate an open-door policy.</p> <p>Completed incident forms and residents' records reviewed demonstrated that family are informed if the resident has an incident/accident, or a change in health. Family and resident interviews confirmed that family are informed of any changes in resident status and that they are invited to the care planning meetings for the resident. The previous finding around open disclosure has been addressed.</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>Brightwater Home is owned and operated by Presbyterian Support Central organisation. The service provides hospital, rest home, dementia level care for up to 58 residents. On the day of the audit there were a total of 51 residents: 25 hospital residents, 4 rest home residents and 22 secure dementia care residents. Included in the total occupancy numbers were five residents who are under a Ministry of Health contact for young persons with disability care (four at hospital level and one at rest home level of care). The remaining 46 residents were under the DHB age related residential contract (ARRC).</p> <p>This audit also included verifying the service has suitable to provide residential disability -physical level care.</p> <p>Presbyterian Support Central (PSC) has an overall business/strategic plan, philosophy of care and mission statement. Brightwater Home has a facility specific business plan, currently under review for 2021, and a quality plan which links to the organisation's strategic plan. The quality plan is reviewed quarterly for progress against quality goals such as community engagement, pressure injury education and care, accommodation for families especially at times of palliative care for residents, training and education for nursing students in aged care (a sharing of information and learning), and fire evacuation training post an upgrading of the system as well as building team cultures and hazard policy and reporting. Not all goals were able to be achieved due to Covid-19 restrictions and will continue in the next quality plan. Benchmarking data identify a downward trend in infections.</p> <p>There is an electronic reporting of events and internal audits that facilitates review of progress against identified</p>

		<p>indicators by the executive management team. A range of performance indicators are monitored including but not limited to: admissions and discharges; staffing; compliments and complaints, infections; falls; weight loss and pressure injuries.</p> <p>The clinical manager (registered nurse with current practicing certificate) has been in the role two years of facility manager for Brightwater Home and another local PSC facility. She was the facility manager for many years prior to accepting the manager role across two sites. She has extensive experience in elderly care. The facility manager reports to the business operations manager and clinical director. The facility manager is supported by a clinical nurse manager with 10 years' experience in aged care and who has been in this role for two years.</p> <p>There are monthly zoom meetings with managers and head office. The facility manager has completed more than eight hours of professional development relating to the management of an aged care service in the past twelve months. She attends quarterly PSC manager meetings which also include manager training such as complaints management, privacy and Maori Health.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The service has a quality and risk management system in place. PSC has an overall Quality Monitoring Programme (QMP) that is part of the quality programme. Interviews with the facility manager and clinical nurse manager reflected their understanding of the quality and risk management systems that have been put into place. The senior team meeting acts as the quality committee and monitors progress with the quality programme/goals through one monthly senior team meetings. The agenda covers quality data relating to accidents/incidents, infections, wounds, internal audits, human resource/staff issues, corrective action plan updates, outcomes of internal audits, health and safety, Eden activity and resident/relative issues, clinical/business risk, complaints, policies, education/training and business plan goals are discussed. Information is fed back to the monthly clinical focused meetings and general staff meetings. The previous finding around quality data and information being provided to staff has been partially addressed however does not cover documentation of key issues being followed up or closed out.</p> <p>There are policies and procedures used to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures are detailed to allow effective implementation by staff. Policies and procedures are reviewed by relevant personnel at head office and relevant advisory group in consultation with managers and clinical managers. Staff have access to A-Z policies on the PSC intranet. Policy changes/reviews are also discussed at staff meetings.</p> <p>The quality and risk management programme includes an annual survey, internal audit programme, data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure injuries.</p> <p>The 2020 surveys results are currently being processed with preliminary results for 2020 demonstrating overall satisfaction rating the home (86%) for care, housekeeping and the menu and dining experience. Areas identified for improvement (those between 70-75%), Culture and spirituality, autonomy and choice and activities of daily living are</p>

		<p>included in the Brightwater Home quality goals for 2021. The facility has already commenced addressing some of these areas, such as employing a Chaplin and a new recreation facilities team over the last six months.</p> <p>Incidents/accidents and infection control events are entered into the electronic system and a monthly report is generated. Quality data that is collected is entered on the PSC database and benchmarked against other facilities in the group. Action plans are developed for any clinical data above the benchmark for key performance indicators. Internal audits have been completed as scheduled. Audit outcomes are discussed, and corrective actions put in place including re-audits for results less than expected, (any achievement under 80% triggers corrective actions). The Brightwater Home collated corrective action report is reviewed at least monthly. Corrective action plans reviewed were comprehensive and signed off when completed.</p> <p>The service has a health and safety management system which includes a revamped Health and Safety and Hazards programme with a new heightened awareness for all staff of health and safety matters, which are raised at all meetings inclusive of hazards. Staff have the opportunity to raise any health and safety concerns for discussion at upcoming meetings. There is a current hazard register for the site covering all areas of service. Staff receive health and safety induction on employment and ongoing training as part of the education programme. Contractors and volunteers receive a health and safety induction. Health and safety audits are now mandatory as a part of the organisations benchmarking.</p> <p>Falls prevention strategies are in place including the analysis of falls and the identification of falls prevention strategies including resident checks, sensor mats, GP post falls reviews, physio input as required and individual resident interventions on a case-by-case basis to minimise future falls.</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</p>	<p>FA</p>	<p>Management is aware of situations which require the facility to report and notify statutory authorities. Interviews and documentation confirmed that these are reported to the appropriate authority. Since the last audit a single unstageable (non-facility related pressure injury) has been reported to HealthCERT as a section 31 notification.</p> <p>Interviews with staff and review of critical event forms confirmed that all staff are encouraged to recognise and report critical events. Staff training records reviewed confirmed that staff receive education on accident/incident reporting processes at orientation and as part of the ongoing training programme. Staff interviewed understood the adverse event reporting process and their obligation to document all untoward events. A review of documentation confirmed that staff document adverse, unplanned or untoward events on accident/incident forms which are signed off by the clinical nurse manager.</p> <p>The service collects a set of data relating to adverse, unplanned and untoward events. The data is generated on the Leecare system and links to the organisational benchmarking programme. Benchmarking reports are received three monthly and displayed for staff.</p> <p>Six incident forms (four falls, one skin tear, and one non facility acquired unstageable pressure injury (section 31 completed for a deceased resident) were reviewed for March 2021. All incident forms had been fully completed and</p>

manner.		<p>residents reviewed by an RN. Progress notes detailed RN follow-up, corrective actions and relative notification. Neurological observation forms were documented and completed for un-witnessed falls with potential head injuries. The clinical nurse manager reviews incidents daily and ensure staff are kept informed at daily handovers.</p> <p>The previous finding relating to neurological observations has been addressed.</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>	FA	<p>Human resources management policies are in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications and experience as evidenced in the six staff files selected for review (two RNs, three healthcare assistants (HCAs) and one recreational officer). All files contained a job description, completed orientation and current performance appraisal (one staff member was a new employee and had yet to have an appraisal). The skills and knowledge required for each position are documented in job descriptions.</p> <p>Healthcare assistants interviewed stated that they believed new staff were adequately orientated to the service. New staff complete a site induction and a role specific orientation. Copies of practising certificates for RNs and allied health professionals were sighted.</p> <p>An in-service education programme is being implemented that includes annual mandatory training days for RNs (professional and core clinical days) and HCAs and other support staff. Staff are required to attend the mandatory training days; speakers include the facility manager and clinical nurse manager. Records of attendance at the training days demonstrates that staff attend as required however, there has been disruption of the education plan due to Covid-19. Individual record of training attendance is maintained. There is additional education offered through the DHB and hospice. Staff complete competencies relevant to their role including medication competencies, manual handling and food safety. There were seven RNs, all RNs and one enrolled nurse (EN) have completed interRAI training.</p> <p>Enliven has a professional development recognition programme for RNs and enrolled nurses that has been approved by nursing council. The facility manager, clinical nurse manger and all RNs have all completed interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager oversees two facilities: Willard (rest home only) and Brightwater. The facility manager spends a half day at each home. The clinical nurse manager works full-time Monday to Friday with support from one clinical co-ordinator (RN). There is 24/7 RN cover within the two hospital/rest home wings and 30 hours of RN cover in the dementia unit (the clinical nurse manager also supports this unit). The clinical nurse manager and RNs share the clinical on call cover.</p> <p>Registered nurses have sufficient time available to complete interRAI assessments and care planning evaluations</p>

<p>qualified/skilled and/or experienced service providers.</p>		<p>within contractual timeframes. There is a first aid trained member of staff on each shift as well as medication competent staff. Healthcare assistants reported a supportive culture, and that RNs were readily available to assist and support when needed.</p> <p>Observation of service delivery confirmed that resident needs were being met in a timely manner. Resident and family interviews stated that staffing is adequate to meet the residents' needs. All leave including booked and unexpected leave was evidenced to be fully covered.</p> <p>HCA staffing in the rest home/ hospital (four rest home residents (including one YPD) and 25 Hospital level residents (including four YPD).</p> <p>Morning shift hospital /rest home(7am-3pm): There are six HCAs on the morning shift with one working the full shift, two working 8am to 3pm, two working 6am-2pm and one working 7am to 1pm.</p> <p>Afternoon shift hospital /rest home (3pm to 11pm): There are six HCAs on the afternoon shift with two working the full shift and two working 3pm to 9pm and two working 4.30pm to 9pm.</p> <p>There are two HCAs in the hospital /rest home on the night shift.</p> <p>The dementia unit has 22 residents; HCA staffing includes.</p> <p>Morning shift dementia unit (7am-3pm): There are three full shift staff.</p> <p>Afternoon shift dementia unit (3pm-11pm) There are two full shift staff and one HCA from 3pm to 9.30pm</p> <p>Night shift dementia unit (11pm-7am): There is one HCA on shift with support from the hospital /rest home.</p> <p>There are designated staff for activities, cleaning and laundry services and food services.</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>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medications are stored safely throughout the facility.</p> <p>Registered nurses, enrolled nurse and medication competent HCA who administer medications have completed annual medication competencies and education. The RNs have completed syringe driver competencies. The RNs reconcile medications (blister packs) on delivery against the electronic medication chart. An impress stock is held for hospital level residents which is checked regularly for stock levels and expiry dates.</p> <p>There was one resident in the dementia care unit that administered an inhaler which was kept on their person. A self-medication competency had been completed. The staff report the resident becomes very agitated if the inhaler is removed.</p> <p>The medication fridge is maintained within the acceptable temperature range with weekly recordings. There is an air conditioning unit in the main medication room and dementia unit medication cupboard set at 19 degrees Celsius.</p>

		<p>All eye drops, ointments and sprays were dated on opening.</p> <p>Ten medication charts reviewed on the electronic system met prescribing requirements. All medication charts had photo identification and allergies/adverse reactions noted. As required medications prescribed indications for use. The 10 medication charts had been reviewed by the GP three monthly.</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>	FA	<p>All meals are prepared and cooked on site at Brightwater Home. There is a well-qualified chef (interviewed) on duty Monday to Friday supported by a weekend cook. There is a morning and afternoon kitchenhand each day. There is a five weekly rotating summer and winter menu that is reviewed by the company dietitian. The menu includes a vegetarian, gluten free and finger foods option. Pureed/soft meals are provided as required. Resident dislikes are accommodated with alternative foods offered. The meals are served from bain-maries. The chef and kitchenhand serve in the dining rooms. The rest home/independent dining room offer self-service. There is a separate dining room for hospital eve residents who require assistance with meals. There is currently construction in the dementia unit kitchenette to commence self-service meals for residents who are independent with meals.</p> <p>All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The chef is informed of dietary changes and any residents with weight loss. Specialised utensils and lip plates are available as required. Nutritious foods were available 24 hours in the dementia care area.</p> <p>The Food Control Plan expires on 23 January 2022. Daily hot food temperatures are taken and recorded for each meal. Fridge and freezer temperatures are recorded daily. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. Temperatures on inward goods are taken and recorded. The chemical provider monitors the dishwasher monthly. There is a cleaning schedule maintained. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.</p> <p>Input from residents' meetings and food surveys, provide feedback on the meals and food services. Residents and relatives interviewed commented very positively on the meals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	FA	<p>A health status summary held in the resident's electronic records documents significant events, investigations, GP visits and outcomes. When a resident's condition changes, the registered nurse initiates a GP or nurse specialist visit if required. Residents and relatives interviewed confirmed care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status including accidents/incidents, infections, GP visit, medication changes and any changes to care and health.</p> <p>Staff reported there are adequate continence supplies and dressing supplies. Supplies of these products were sighted on the day of the audit.</p>

desired outcomes.		<p>There were seven residents (three hospital, three dementia and two rest home level) with wounds (skin tears, lesions and one surgical wound). There were no pressure injuries being treated on the day of the audit. Wound assessments had been completed for all wounds. There was evidence of district nurse involvement for one surgical wound. The GP reviewed wounds at RN request. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury. There was sufficient pressure relieving equipment.</p> <p>Behaviour management plans had been developed in the two dementia care resident files reviewed. Triggers, sign and symptoms for changes in behaviour was documented including the potential behaviours. Interventions were described in the management plan including de-escalation and activities. Behaviour monitoring forms had been completed with any behaviours of concern.</p> <p>Monitoring forms are used to monitor a resident's progress such as observations, weight, blood sugar levels, food and fluid, pain, bowel, repositioning and neurological observations.</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>	FA	<p>There are three recreational therapists who implement and coordinate activities seven days a week from 9am-4.30pm across the three levels of care. There are three recreation officers who coordinate activities across seven days a week. Two are currently enrolled in DT apprenticeship. There are six volunteers involved in activities with residents such as discussions, bingo, karaoke, gardening, knit and knatter, and one on one time. Some activities are integrated for all residents and the programme identifies the lounge or activity room for the activity.</p> <p>Other activities include (but not limited to); board games, word games, arts and crafts, baking, singing and exercises. Music appreciation (one on one) is held daily. One on one time is spent with residents who choose not to join in group activities or stay in their rooms. Residents are encouraged to be involved in the planning of events through "sharing circles" (meetings). There a plenty of resources in the dementia care unit for HCAs to engage in activities with the residents when the recreational officer is not in the unit. Community visitors to the facility include churches services and entertainers. There are outings into the community such as church events/concerts, men's shed, scenic drives and inter-home visits.</p> <p>There is a younger person group with activities including golf, skittles and age-appropriate music sessions. The younger people receive a copy of the programme and can choose to attend any of the group activities. They have outings and enjoyed the recent inter-home picnic. The younger people have family connections and enjoy going out with their families.</p> <p>Resident feedback includes one-to-one feedback and an annual survey. The residents and relatives interviewed commented positively on activities offered.</p>
Standard 1.3.8:	FA	Six-monthly evaluations of the long-term care plan were evident in the files of residents who had been at the service longer than six months. Resident/family were involved in care plan evaluations. Case conference notes were

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>maintained that included changes to care and if the resident goals had been met or not. The six-monthly evaluation of care involved the input from care staff and other allied health professionals involved in the care of the resident. Long term care plans had been updated with any changes to care following the case conference.</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 2021. Building warrant of fitness checks were underway. The maintenance person (interviewed) is contracted and working between two facilities until the Brightwater maintenance vacancy has been filled. The maintenance request book is checked daily, and maintenance carried out or contractors called to address the issue. The monthly maintenance plan has been maintained and completed as scheduled. Electrical equipment has been tested and tagged. Clinical equipment is calibrated annually. Hot water temperatures are recorded monthly and are maintained below 45 degrees Celsius.</p> <p>The corridors are wide and promote safe mobility for the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There are outdoor areas with seating and shade. The dementia wing has a safe outdoor grounds and gardens with a circular walking pathway, raised garden beds, seating and shade. There are four entry/exit doors into the gardens and back into the unit.</p> <p>The HCAs and registered nurses stated they have enough equipment to safely deliver the cares as outlined in the resident care plans.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (clinical co-ordinator) was on leave at the time of audit and her role was being filled by the clinical nurse manager. Infection events are collated on the Leecare system and data analysed for trends. Infection control data is discussed at facility meetings. The information obtained through surveillance is used to determine infection control activities, resources and education needs. Monthly data is submitted to head office for benchmarking and feedback to the service. Corrective actions for events above the benchmarking (KPIs) is reported to the senior team. Internal infection control audits also assist the service in evaluating infection control needs.</p> <p>The facility continues to screen visitors to the facility and there are hand sanitisers strategically placed throughout the facility. There was additional staff education focused on Covid-19 outbreak management, hand hygiene and correct use of personal protective equipment. The Brightwater Home PSC pandemic plan was submitted to the DHB and there was ongoing support with regular zoom meetings with the DHB. There were regular zoom meetings between head office PSC facility managers and clinical managers. The facility has sufficient personal protective equipment on-site. The facility manager commented positively on the DHB support which has been ongoing. There</p>

		have been no outbreaks since the last audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. The clinical nurse manager is the restraint coordinator has had training in restraint minimisation and safe practice. A signed position description was sighted. The restraint register is maintained.</p> <p>There were seven residents with restraint and one resident with an enabler on the day of audit. The care plans for two resident files with restraints reviewed. The information documented gave clear indication of the need for the restraint and the risk involved to allow for assessment. Ongoing consultation with the resident and family/whānau is also identified. Consents were appropriately signed.</p> <p>Restraint minimisation, enablers and behaviour of concern education is completed on orientation and included in the education planner.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA</p> <p>Moderate</p>	<p>Key quality meetings such as senior staff meetings, and clinical meetings and staff meetings document that data is discussed, including infection control, restraint, incidents and accidents. Meeting minute documentation has been updated and is more robust in content since the last audit, but does not detail follow up of issues raised with outcomes and date of closure.</p> <p>The previous finding around quality data and information being provided to staff has been partially addressed, but still does not cover documentation of key issues being followed up or closed out.</p>	<p>Meeting minutes do not document that issues raised are followed up or closed out when completed.</p>	<p>Ensure that the issues raised at meetings are documented as followed up /or closed out as appropriate.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.