

# Presbyterian Support Central - Brightwater Home

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## 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:

<b>Legal entity:</b>	Presbyterian Support Central
<b>Premises audited:</b>	Brightwater Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 4 July 2019      End date: 5 July 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	52

# 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

Brightwater Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home, hospital and dementia level of care for up to 58 residents. On the day of audit there were 52 residents.

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, management and the general practitioner.

The facility manager/registered nurse has been in the role since April 2019 and manages Brightwater Home and another PSC facility. The facility manager has many years' experience in aged care. The facility manager is supported by an experienced clinical nurse manager who has been at Brightwater for eight years and in the position for 12 months. The management team are supported by a clinical director, general manager and interim chief executive officer at head office. The clinical nurse manager is supported by two clinical coordinators, a team of registered nurses and stable workforce. Residents and family interviewed spoke positively about the service provided and family communication.

This audit identified improvements required around open disclosure, quality programme and incident reporting/

## 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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The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Residents receive services in a manner that considers their dignity, privacy and independence. Policies are implemented to support residents' rights, and complaints management. The service promotes and encourages good practice. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## 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 PSC quality and risk management system documented that supports the provision of clinical care. A series of meetings are in place to support the quality system. An annual resident and relative satisfaction survey are completed and there are regular resident and relative meetings. 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 mandatory requirements and 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.		Standards applicable to this service fully attained.
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Brightwater Home provides an admission package with information on the services provided prior to or on entry to the service.

Assessments, planning and review 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 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.

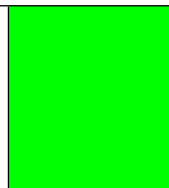
The activities programme provides diversional therapy activities for residents which are varied and include one to one and group activities, community involvement and outings.

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 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.

Brightwater Home has a current building warrant of fitness. All rooms are single and personalised. There is adequate room for the safe delivery of hospital, dementia and rest home level of care within the resident's rooms. 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 for residents to be able to walk. There is wheelchair access to all areas.

Housekeeping staff maintain a clean and tidy environment. All laundry is completed on site. Chemicals were stored safely throughout the facility. Appropriate policies are available along with product safety charts.

There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Appropriate training, information and equipment for responding to emergencies are provided. The registered nurses and diversional therapy staff are first aid trained. A van is available for transportation of residents.

## 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.

There is a restraint policy in place that states 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. On the day of audit there

were six residents with restraints and one with an enabler. Restraint minimisation, enabler use, and challenging behaviour training 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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating education and training for staff. The infection control coordinator attends PSC peer support meetings for infection control coordinators. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks since the previous audit.

## 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	47	0	3	0	0	0
<b>Criteria</b>	0	98	0	3	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. There are policies in place that reflect the Code and how it is implemented. Staff can describe how the Code is incorporated in their everyday delivery of care. Interviews with eleven care staff; including five healthcare assistants, five registered nurses, and one diversional therapist reflected their understanding of the key principles of the Code. Staff receive training about the Code in the mandatory in-service training programme.</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>An admission package with information on the services provided is given to prospective residents and or their family/whānau prior to or on admission. Policies and procedures for informed consent policies/procedures and resuscitation are in place. General consents and specific consents where applicable, were obtained on admission and updated as required. These were sighted in the eight residents' files reviewed (three hospital and three dementia resident files and two rest home resident files). Resuscitation plans were appropriately signed. Copies of enduring power of attorney (EPOA) for care and welfare were in resident files for residents deemed incompetent to make decisions.</p> <p>Systems are in place to ensure residents, and their family/whānau (where appropriate), are provided with appropriate information to make informed choices and decisions. Discussions with staff confirmed consent is obtained when delivering care. A signed admission agreement was in place for the files</p>

		reviewed. Discussions with family/whānau confirmed that the service actively involves them in decisions that affect their relative's lives.
<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>	FA	A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the main entrance. The information pack provided to residents at the time of entry to the service also 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>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>	FA	Interviews with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Maintaining links with the community is encouraged. Discussion with staff, relatives and residents confirmed residents are supported and encouraged to remain involved in the community and external groups. There are several volunteers actively involved in assisting/supporting residents in activities.
<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 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 the clinical manager for clinical concerns/complaints. A complaint register (on-line) records acknowledgement of complaints, investigation and resolution, including advocacy information within the required timeframes. Enliven concern/complaint forms are visible at the main entrance. There have been six complaints for 2018 and three written complaints to date for 2019.</p> <p>One complaint resulted in a section 31 report and the resident transferred to the DHB (a different level of care was required) and one DHB complaint regarding care was comprehensively followed up and discussed in staff and senior staff meetings.</p> <p>Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaint 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</p>	FA	Code of Rights information was available in the front entrance of the facility and posters were on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets were available at the front entrance. Information is also included in the welcome pack which is given to the resident/relative prior to or on entry to the service. Interviews with seven residents

rights.		(two rest home and five hospital) and four family members (two hospital and two dementia care relatives) confirmed that the service functions in a way that complies with the Code of Rights.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<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 peoples' beliefs and values. A tour of the facility confirmed personal privacy is provided and respected for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff were respectful, caring and maintain their dignity, independence and privacy always. 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.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>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.</p>	FA	<p>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's philosophy results in each person's cultural needs being considered individually.</p> <p>PSC have recently developed a Māori Health Plan which was developed in partnership with local Whanganui Kaumātua, whānau, residents and staff. It incorporates the Māori Health Strategy (He Korowai Oranga), Dr Mason Durie's Te Whare Tapa Whā, Treaty of Waitangi Principles and The Eden Alternative core principles. On the day of audit there were six residents who identified as Māori. One file reviewed for a resident who identified as Māori had a very comprehensive Māori health care plan in place. One resident who identified as Māori interviewed, stated that his cultural needs were met. Linkages with local Iwi are documented.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the clinical nurse manager or registered nurses (RN), along with the resident and family/whānau complete the cultural and spiritual documentation. Residents and family interviewed confirmed 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 can visit at any time of the day. Spiritual and pastoral care is an integral part of service provision. The service employs a chaplain who provides support to resident's, families and staff.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Discrimination, coercion, exploitation and harassment policies and procedures are 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 mandatory in-service training. Interviews with staff confirmed their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. The code of conduct and confidential clause and information technology policy is signed on employment.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the Health and Disability Services Standards. Staffing policies include pre-employment and the requirement to attend orientation and ongoing mandatory in-service training. The clinical manager and clinical coordinators and RNs have regular visits (three monthly) from the PSC nurse consultants and are readily available by phone. Staff interviewed had a sound understanding of principles of aged care. Staff stated that they feel supported by the management team. The service demonstrates they are continually striving to provide quality care and have achieved all ten of the Eden principles. Brightwater has implemented the Leecare resident management system with intention to streamline clinical documentation. Brightwater Home went live in March 2019. Once a year, each home is peer reviewed by senior staff from other homes. This has resulted in sharing of quality improvement ideas between homes. It has also enabled Enliven to make improvements at all homes, based on the learnings from the Health Checks.</p> <p>Brightwater achieved the Enliven best team award 2019 for a project to improve team culture.</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>PA Low</p>	<p>There is an open disclosure policy. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services, and charges not included in the admission agreement. Ten incident forms reviewed from May 2019 on the Leecare system did not all identify that the relative had been informed of the accident/incident. Relatives interviewed confirmed they were notified of any changes in their family member's health status. There are regular resident meetings and Eden meetings. Brightwater have commenced a family and resident newsletter with two issues so far. Interpreter services are provided as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and</p>	<p>FA</p>	<p>Brightwater Home is owned and operated by Presbyterian Support Central organisation. The service has a capacity of 58 beds. It provides 26 dedicated hospital level beds, plus eight dual-service (rest home and hospital) beds and 24 dementia level of care beds. On the day of the audit there was a total of 52 residents. There were four rest home residents; including one younger person disabled, 27 hospital level of care residents; including three younger people disabled and 21 dementia care residents</p>

<p>appropriate to the needs of consumers.</p>		<p>including one respite resident.</p> <p>Presbyterian Support Central (PSC) has an overall business/strategic plan, philosophy of care and mission statement. PSC Brightwater has a facility specific 2019-2020 business plan which links to the organisation's strategic plan and is reviewed at quarterly meetings. PSC have developed advisory groups that involve representation from PSC facilities on quality, training, Eden philosophy, cultural advisory and business development. There is evidence the business plan is being reviewed quarterly and reported on. Goals include service growth, community linkages, environmental improvements and enhancement of team culture. Staff are involved in goal setting.</p> <p>The facility manager (registered nurse with current practicing certificate) has been at the facility since the 1 April 2019. The facility manager also manages another close by PSC facility where she has been the facility manager since 2015. The manager divides her time equally between the two facilities. Staff interviewed expressed how happy they were with the new manager and her open-door approach and supportive management.</p> <p>The facility manager reports to the clinical director and general manager at head office and attends the quarterly managers meetings. The facility manager is supported by an experienced clinical nurse manager who is based in Brightwater home.</p> <p>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, including attending the PSC manager peer support meetings. The facility manager received a site induction on appointment.</p> <p>The facility manager and clinical nurse manager attend the local DHB forums. The clinical manager attends clinical manager peer support meetings which include leadership training.</p>
<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>	<p>FA</p>	<p>The clinical nurse manager who is employed full time, covers the facility manager absence with support from the clinical director/general manager and administrator.</p>
<p>Standard 1.2.3: Quality And Risk</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. The senior team meeting acts as the quality</p>

<p><b>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>		<p>committee and monitors progress with the quality programme/goals through meetings. Clinical meetings are held monthly. Key quality data is not documented as discussed at meetings, including; infection control, restraint, incidents and accidents and issues raised are not always documented as followed up at subsequent meetings. General staff meetings are held monthly. Meeting minutes for all meetings are made available to staff.</p> <p>There are policies and procedures (including Lippincott NZ) 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.</p> <p>The quality and risk management programme includes (but not limited to) an annual survey, internal audit programme, data collection, analysis and review of adverse events including accidents, incidents, infections, wounds and pressure injuries. The overall survey result for 2018 was a score of 5.0, which was an improvement on the previous year. An analysis of specific areas surveyed demonstrated an improvement year-on-year.</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.</p> <p>The service has a health and safety management system which includes a health and safety committee. Committee meetings are held three monthly. Staff are informed of upcoming health and safety meetings and have the opportunity to raise any concerns with representatives. Committee meeting minutes are posted on the health and safety board in the staffroom. 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.</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, post falls reviews and individual resident interventions on a case-by-case basis to minimise future falls.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or</p>	<p>PA Low</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 and this can be used for comparative purposes with other similar services. Trends and analysis information and</p>

<p>untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>graphs are available to staff (link 1.2.3.6). Ten incident forms across the three services for May 2019 were reviewed. All incident forms (skin tears, falls, bruises, pressure injury and behaviours) had been fully completed and residents reviewed by a RN. Progress notes detailed RN follow-up, corrective actions and relative notification. Neurological observation forms were not always documented and completed for unwitnessed falls with potential head injuries.</p> <p>Discussions with the facility manager and clinical nurse manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three section 31 notifications since the last audit. One for a resident who was transferred to hospital, one for a pressure injury and one for a resident who was transferred to hospital following a notice to leave the facility. There have been no outbreaks since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<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 eight staff files selected for review (two RNs, two clinical coordinators, three healthcare assistants and one cook). All files contained a job description, completed orientation and current performance appraisal. Care staff interviewed stated that they believed new staff were adequately orientated to the service. Copies of practising certificates for RNs and allied health professionals were sighted.</p> <p>A three-year in-service education programme is being implemented. Records of attendance at the training days demonstrates that staff attend as required. Individual record of training attendance is maintained. Training days are evaluated, and training opportunities are identified. There is additional education offered through the DHB and hospice. Enliven has a professional development recognition programme for RNs and enrolled nurses that has been approved by nursing council. All nine RNs, including the clinical nurse manager have completed interRAI training.</p> <p>There are ten HCAs who work in the dementia unit and all have completed the dementia unit standards.</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. Sufficient staff are rostered to manage the care requirements of the residents. The facility manager works between two facilities and the clinical nurse manager works full-time at Brightwater. The two clinical coordinators work seven days a week between them across a variety of shifts. The clinical nurse manager and two clinical coordinators provide clinical on-call cover. There is one RN on duty 24 hours, based in the hospital wing.</p> <p>Healthcare assistant staffing is as follows;</p>

		<p>Dementia unit: (21 residents on day of audit), three HCA for the AM, two long and one short shift for the PM and one on nights.</p> <p>Hospital/rest home: (4 rest home and 27 hospital residents on day of audit), four long shifts and two short shifts for the AM, two long shifts and four short shifts for the PM shift and two on nights.</p> <p>There are designated staff for activities, cleaning and laundry services and food services.</p> <p>Interviews with residents and family members identified that staffing is adequate to meet the needs of residents.</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>	FA	<p>The resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. A document destruction bin is used for confidential documents. All electronic resident files are password protected.</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>Prior to entry to Brightwater Home, potential residents have a needs assessment completed. Registered nurses may also visit potential residents prior to admission. The service has an admission policy, admission agreement and a resident information pack available for residents/families/whānau at entry. The information pack includes all relevant aspects of the service. Eight Brightwater Home admission agreements viewed were all signed. Admission agreements in the files reviewed align with contractual requirements. Exclusions from the service are included in the admission agreement. The clinical nurse manager and clinical coordinators described the entry and admission process. All three resident files for the dementia unit included a NASC assessment for secure dementia level care and an enacted EPOA.</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>A pink envelope, transfer document, summary care plan and medication profile are electronically generated when residents are transferring to hospital. All relevant information is documented and communicated to the receiving health provider or service. Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner.</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. There are two medication rooms in the facility. The medication trolleys are kept in locked rooms.</p> <p>Registered nurses, the enrolled nurse or medication competent carers administer medications from blister packs on medication rounds. These staff have been assessed for competency on an annual basis and attend annual medication education. RNs and the enrolled nurse attend syringe driver education. All medication is checked on delivery against the electronic medication chart. All medications were securely and appropriately stored. There were no residents self-medicating on the day of audit. The medication fridge is maintained within the acceptable temperature range. All eye drops, and ointments were dated on opening.</p> <p>Sixteen medication charts reviewed met legislative requirements; all charts had photo identification and allergies/adverse reactions noted, and 'as required' medications prescribed correctly with indications for use. Medications had been signed as administered in line with medication charts. The sixteen medication charts included three monthly GP reviews. Appropriate practice was demonstrated on the witnessed medication around.</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 are prepared and cooked on site at Brightwater Home. The Food Control Plan expires on 23 January 2020. The food services team leader is responsible for the operations of food services. The kitchen team includes a weekend cooks and kitchenhands. There is a five weekly rotating summer and winter menu that is reviewed by the company dietitian. A food services policies and procedures manual is in place.</p> <p>All residents have their dietary requirements/food and fluid preferences recorded on admission and updated as required. The cook maintains a folder of resident's dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, pureed meals and finger foods. Gluten free options were available for a resident requiring gluten free options. Specialised utensils and lip plates are available as required. Snacks were available as required for residents in the dementia care area.</p> <p>Input from residents and food surveys, provide resident feedback on the meals and food services. Residents and relatives interviewed confirmed likes/dislikes are accommodated and alternative choices offered.</p> <p>Daily hot food temperatures are taken and recorded for each meal. A bain marie is used to serve food</p>

		<p>in the dining room and to deliver foods to residents in other dining areas and to their rooms. Holding temperatures are taken. Fridge and freezer temperatures are recorded. Dry foods in the pantry are dated and sealed. Perishable foods in the chiller and refrigerators are date labelled and stored correctly. The kitchen has a separate dishwashing area, preparation, cooking, baking and storage areas.</p> <p>The chemicals are stored safely. The chemical supplier completes quality control checks on the sanitiser. Safety data sheets are available, and training provided as required. Personal protective equipment is readily available, and staff were observed to be wearing hats, aprons and gloves.</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 the organisation, where appropriate.</p>	FA	<p>If entry is declined, the management staff at Brightwater Home communicate directly with the referring agencies and potential resident or family/whānau as appropriate. The reason for declining entry to the service would be if there were no beds available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>There was evidence in files sampled that the registered nurse completed an initial admission assessment within 24 hours which includes relevant risk assessment tools for all residents. Risk assessment tools include (but are not limited to) assessment for cognitive function; continence; dietary; falls risk; pain and pressure injury risk. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others.</p> <p>Of the eight files reviewed three residents did not require interRAI assessments. One resident who was respite did not have an interRAI assessment. One resident who was a younger person did not have an interRAI. One other resident who was also on a YPD contract but was over the age of 65 years did have current six monthly interRAI assessments completed. Five long-term residents under the ARC had interRAI assessments completed within the required timeframe. Additional assessments for management of wound care and infection were appropriately completed according to need. The long-term care plans reviewed reflected the outcome of the assessments.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p>	FA	<p>The registered nurse develops the long-term support plan from information gathered over the first three weeks of admission. Resident needs and supports are identified through the ongoing assessment process in consultation with the resident/relative and significant others. Residents had a tree of life that</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>outlined their personal story, likes and dislikes.</p> <p>The support plans sampled reflected the outcomes of risk assessments. Interventions clearly described support required. Each resident file sampled had a risk summary and detailed the resident's medical problems and alerts such as high falls risk. In the files sampled there was documented evidence of resident/relative/whānau involvement in the support planning process.</p> <p>Short-term care plans are available for use to document any changes in health needs with interventions, management and evaluations. Short-term care plans sighted included management of infections, wounds, and behaviour management. There was evidence that short-term care plans sampled had been evaluated at regular intervals and integrated into the long-term care plan if the problem was ongoing. Medical GP notes and allied health professional progress notes were evident in the residents integrated files sampled.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>A health status summary held in the resident's electronic records documents significant events, investigations, GP visits and outcomes. The registered nurse initiates a review when there is a change in the resident's condition and arranges 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. Resident files sampled recorded communication with family (link 1.1.9.1).</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> <p>There were six wounds and no pressure injuries being treated on the day of the audit. In the hospital, three residents had four wounds. One hospital resident had two wounds. In the dementia care area two residents had a wound. Wound assessments had been completed for all wounds. There was evidence of community wound health nurse involvement for one wound. There was evidence of GP involvement for two of the residents with wounds. Pressure injury prevention interventions were documented in the care plans for residents identified at risk of pressure injury.</p> <p>Behaviour management plans are developed with multi-disciplinary input and describe types of behaviour, possible triggers and interventions. There was evidence that the GP had initiated specialist referrals to mental health services when required for residents.</p> <p>Resident care plans (short-term and long-term) document appropriate interventions to manage clinical risk such as behavioural management, falls, skin integrity and nutrition. Caregivers interviewed confirmed they are updated of any changes in resident's care or treatment during handover sessions. The active short-term care plans and long-term care plans are in the electronic software system used for</p>

		resident care.
<p><b>Standard 1.3.7: Planned Activities</b></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>The service employs a diversional therapist, and two recreation officer. A chaplain provides spiritual and pastoral care to residents. There are a team of 14 volunteers. The volunteers include two people who play the piano; one artist who provides art therapy; one person who provides pet therapy; and two people who provide one-to-one sessions with the residents. The team provides activities across the rest home, hospital, and dementia care areas.</p> <p>The activities programme is displayed on a calendar. It includes chair exercises, housie, baking, and crafts. Speakers have included personnel from Bunnings and the police. The local kindergarten children visit once per week, and the residents visit them. Examples of outings to the community included regular outings to cafés. During café visits the residents participate in a café review, where they rate the café. This proves to be popular. At other times, residents may be taken one-to-one on shopping visits as required for clothes or other items. A van is available for community outings and staff have first aid training.</p> <p>Resident feedback includes one-to-one feedback and a general survey. The volunteers have been surveyed about their input. There was evidence within the programme of activities being provided to reflect the residents needs in the dementia care area; and to reflect the needs of younger residents. The residents and relatives interviewed commented positively on activities offered.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Five of the eight residents' files sampled had been in the facility for longer than six months. Six-monthly evaluations of the support plan were evident in the files reviewed. Resident/family were involved in care plan reviews of those files reviewed. The long-term support plans reviewed evidenced that the support plan was amended with each review if there were changes identified. Weight, blood pressure and pulse, fluid balance charts, food and fluid intake charts, blood sugar level monitoring and behaviour monitoring charts are in use. Short-term care plans reviewed were evaluated regularly with problems resolved or they were integrated into the long-term support plan if there was an ongoing problem.</p>
<p><b>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</b></p> <p>Consumer support for access or referral to other health and/or</p>	FA	<p>Referral to other health and disability services is evident in the resident files sampled. Referral documentation is maintained on resident files. A pink envelope is used and a transfer document, summary care plan and medication profile are electronically generated when residents are transferring to hospital. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and their families are kept informed of the referrals made by the service. The</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>registered nurses interviewed described the referral process to other medical and non-medical services.</p>
<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>	<p>FA</p>	<p>The service has policies and procedures for the disposal of waste and hazardous material. There is an incident system for investigating, recording and reporting all incidents. The chemicals supplies are kept in locked cupboards in service areas. A chemical spills kit is available. The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment (gloves, aprons, goggles) are readily available to staff.</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 2020.</p> <p>The maintenance person is employed Monday to Friday 5.5 hours per week. There is one volunteer who also assists with maintenance. The maintenance person carries out minor repairs and maintenance, reactive and preventative maintenance. There is an annual maintenance plan, with monthly checks, which include hot water temperatures, testing the generators, maintenance of resident equipment and safety checks. Electrical equipment has been tested and tagged. Clinical equipment is calibrated annually. Essential contractors are available after hours.</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 perimeter fence. There is wheelchair access to all areas.</p> <p>The facility has a van available for transportation of residents with a current warrant of fitness and registration. Those staff transporting residents hold a current first aid certificate.</p> <p>The HCAs and registered nurses stated they have enough equipment to safely deliver the cares as outlined in the resident care plans. There are adequate storage areas for hoist, wheelchairs, products and other equipment.</p> <p>There is a designated external smoking area for residents.</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>All resident rooms are single; and two rooms have ensuites. There are adequate communal toilets. The ensuites have appropriate flooring and handrails. There are vacant/occupied signs and privacy locks. Call bells are available in all toilet/shower areas.</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 rooms in the facility are of an adequate size for rest home or hospital level of care. The bedrooms allow for the resident to move about the room independently or with the use of mobility aids. The hospital bedrooms are spacious enough to manoeuvre hoists and hospital level lounge chairs. The bedrooms have wide doors for ambulance or bed entry/exit. Residents and their families are encouraged to personalise the bedrooms as viewed. The auditor confirmed the bedrooms are sufficiently spacious and personalised.</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>The facility has separate rest home, hospital and dementia dining areas with open plan lounge rooms. Seating is placed appropriately to allow for groups and individuals to relax or take part in activities. Residents were observed safely moving between the communal areas with the use of their mobility aids. There is adequate space within the hospital communal areas for the easy manoeuvre of specialised lounge chairs. There are several lounge areas for communal activities, quiet activities and private meetings with family/visitors and an on-site chapel.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All personal clothing and laundry are laundered on site. There is a laundry person on duty seven days a week 6.5 hours per day. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped, and the machinery is regularly serviced. Personal protective clothing is available including gloves, aprons and face masks. Adequate linen supplies were sighted. There are policies and procedures which provide guidelines regarding the safe and efficient use of laundry services.</p> <p>Cleaners are available daily. The cleaners are on site to clean the many communal living areas, bathrooms and toilets. The cleaners' cupboard containing chemicals is locked. Cleaners' trolleys are well equipped and kept in locked areas when not in use. All chemicals have manufacturer labels.</p>

		Cleaning staff were observed to be wearing appropriate personal protective equipment. The environment on the day of audit was clean and tidy. There is a daily and monthly room clean schedule. The cleaning staff have completed chemical safety training.
<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>	FA	<p>There is an emergency management business management plan in place to ensure health, civil defence and other emergencies are included. Staff interviewed were able to describe the emergency management plan and how to implement this. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is always on duty with a current first aid certificate. Six-monthly fire evacuation drills have been completed. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>There are civil defence supplies including radios, batteries and food. There are portable generators, barbeques and gas bottles available. There is enough bottled water and an external water tank.</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. The resident room assessed as suitable for a double room has a call bell with a double call bell extension.</p> <p>Afternoon and night shift complete security rounds of the facility. The building is secure after hours. There is call bell access to the facility.</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>	FA	<p>All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated and kept at a comfortable temperature. Residents and relatives interviewed confirmed the environment and the bedrooms are warm and comfortable.</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</p>	FA	<p>The infection control coordinator is a clinical coordinator and has a current job description. Infection control reporting is integrated into the senior team meeting for discussion around events, trends and corrective actions, this is not well documented (link 1.2.3.6). The infection control programme, and its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The scope of the infection control programme policy and infection control programme description is available. The programme is reviewed annually in consultation with all PSC infection control coordinators peer support day held with the clinical director and nurse consultant.</p>

size and scope of the service.		Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There is sufficient personal protective equipment available. Residents are offered the influenza vaccine. There have been no outbreaks.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The clinical nurse manager has completed a postgraduate certificate in infection control. She attends the annual peer support training within the organisation that includes in-service, review of policies/procedures, outbreak management and sharing of information/experiences. The infection control coordinator has access to expertise within the organisation, DHB infection control nurse specialist, public health, GPs and laboratory service.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a range of IC policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. The infection control policies and procedures are developed and reviewed by the organisational policy review group.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection control education is part of the three-yearly cycle of mandatory training schedule. All staff complete infection control education and workbook on orientation. Toolbox talks at handovers include discussions around topical infection control matters or resident concerns. Infection control is discussed at all facility meetings. Hand hygiene audits are completed annually. There is an infection control board in the staff room with notices that keep staff informed on infection control matters.  Resident education is expected to occur as part of daily activities.



<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 uses the information obtained through surveillance to determine infection control activities, resources and education needs at Brightwater. The RNs complete an infection event form which alerts the infection control coordinator of resident infections. Monthly infection events are collated on the Leecare system with an end of month trends and analysis. Corrective actions for events above the benchmarking KPIs is reported to the senior team and clinical/RN. Internal infection control audits also assist the service in evaluating infection control needs.</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 six residents with restraints (bed rails and lap belts) and one resident with an enabler (bed rails). Documentation was reviewed for two residents using a restraint and one resident with an enabler. Restraint minimisation and challenging behaviour training was completed as part of the service training plan.</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>FA</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. One enabler and two restraint files had their restraint assessments fully documented.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<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.</p> <p>Care plans reviewed, of residents with restraints and enablers, included specific interventions to manage the identified risks. Monitoring forms were 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 GP reviews and six-monthly multidisciplinary meeting and includes family/whānau input.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<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 coordinator.</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>	FA	<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. Restraint use has a specific restraint report and issues are followed up (link 1.2.3.6). Annual organisational restraint meetings and reviews are documented.</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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Open disclosure policy requires that family are kept informed of changes to the resident care needs and any incidents. RNs interviewed agreed that family are informed following and incident, however this was not always documented.	Of the ten resident related incident forms reviewed, three did not evidence that family had been informed, progress notes review for the same incidents also did not evidence family had been informed.	<p>Ensure that family communication is documented following an incident or accident.</p> <p>90 days</p>
<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>	PA Low	Staff interviewed stated that meetings discuss all quality data and that they are always informed of issues and trends. Senior staff and clinical meeting minutes reviewed did not document this information and discussion.	Key quality meetings such as the senior staff meeting, and the clinical meetings do not document that key quality data is discussed and issues raised though meetings are not always followed up. The new manager has recognised this issue and a plan is documented going forward to ensure the meeting minutes are robust and follow discussion points from meeting to meeting.	<p>Ensure that key quality data is documented as discussed including infection control, restraint, incidents and accident.</p> <p>Ensure the issues</p>

				<p>raised in meetings are documented as followed up.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>There is a policy around neurological observations that includes timeframes for observations. The timeframes have not always been followed.</p>	<p>Of the ten incident falls reviewed, four required neurological observations. All four had the observations commenced, three only documented two to three sets of observations.</p>	<p>Ensure that neurological observations are completed over the period of time set by the service or progress notes include why they were discontinued.</p> <p>90 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.